

Electronically delivered March 23, 2023

Administrator Good Samaritan Society - International Falls 2201 Keenan Drive International Falls, MN 56649

RE: CCN: 245318

Cycle Start Date: December 2, 2022

Dear Administrator:

On December 21, 2022, we notified you a remedy was imposed. On January 23, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 17, 2023.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective January 20, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 21, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 20, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 17, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumalu #3ke-Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



Electronically delivered

March 23, 2023

Administrator Good Samaritan Society - International Falls 2201 Keenan Drive International Falls, MN 56649

Re: Reinspection Results

Event ID: ZQNK12

Dear Administrator:

On January 23, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 2, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



Electronically delivered December 21, 2022

Administrator Good Samaritan Society - International Falls 2201 Keenan Drive International Falls, MN 56649

RE: CCN: 245318

Cycle Start Date: December 2, 2022

Dear Administrator:

On December 2, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 20, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 20, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 20, 2023.

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

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,292; 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 January 20, 2023, 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 - International Falls will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 20, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the
 deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.

- The date that each deficiency will be corrected.
- ullet An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 2, 2023 if your facility does not achieve

substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145

Cell: (507) 361-6204 Fax: (651) 215-0525 Email: william.abderhalden@state.mn.us

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumala #3ke-Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 01/09/2023 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION ING | | ` ' | E SURVEY PLETED |
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| | | 245318 | B. WING | | | | C 0 2/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | <u> </u> | ·I | STREET ADDRESS, CITY, STATE, ZI | P CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONAL FALLS | | 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN | 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ION SHOULD HE APPROPE | BE | (X5) COMPLETION DATE |
| E 000 | Initial Comments | | EC | 000 | | | |
| | compliance with Appreparedness Required during a survey. The facility The facility is enroll Correction (ePoC) and required at the State form. Although required, it is required. | ed in the electronic Plan of and therefore a signature is bottom of the first page of the gh no plan of correction is red that you acknowledge | | | | | |
| F 000 | receipt of the electr | | FC | 000 | | | |
| | recertification surve facility. Complaint i conducted. Your fac- compliance with the | gh 12/2/22, a standard by was conducted at your investigations were also cility was found to be not in e requirements of 42 CFR 483, ments for Long Term Care | | | | | |
| | was found to be SU | laint H53186033C (MN87700) JBSTANTIATED; however, no ited due to actions taken by | | | | | |
| | The following comp UNSUBSTANTIATE H53185928C (MN8 H53186929C (MN8 H53186026C (MN8 H53186027C (MN8 H53186029C (MN8 H53186030C (MN8 H53186030C (MN8 | 37574) 9875) 35414) 36687) 36440) 35379) | | | | | |
| LABORATOR | / DIRECTOR'S OR PROVID | DER/SUPPLIER REPRESENTATIVE'S SIG | NATURE | TITLE | | | (X6) DATE |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

(X6) DATE

12/30/2022

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.

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP A. BUILDING | Γ` | X3) DATE SURVEY COMPLETED |
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| | | 245318 | B. WING | | C 12/02/2022 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE NTERNATIONAL FALLS, MN 56649 | |
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| F 637 | as your allegation of Departments accept enrolled in ePOC, you at the bottom of the form. Your electron be used as verificated. Upon receipt of an onsite revisit of you validate that substate regulations has been comprehensive As CFR(s): 483.20(b)(2)(ii) Which determines, or short there has been a sire resident's physical purpose of this second means a major decresident's status the itself without further implementing standing the requires interdisciption care plan, or both.) This REQUIREMENT by: Based on interview | f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an are facility may be conducted to antial compliance with the en attained. sessment After Significant Chg (2)(ii) Aithin 14 days after the facility all have determined, that gnificant change in the or mental condition. (For tion, a "significant change" eline or improvement in the lat will not normally resolve intervention by staff or by dard disease-related clinical has an impact on more than ident's health status, and linary review or revision of the | F 637 | | 1/17/23 |
| | significant change i when two or more a | n status assessment (SCSA) areas of change in resident ed for 1 of 5 resident (R34) | | 1. How corrective action will be accomplished for those residents for have been affected by the deficient | und to |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION NG | ` ′ | E SURVEY IPLETED |
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| F 637 | Continued From pa | age 2 | F 63 | 37 | | |
| | reviewed for activiti | ies of daily living. | | practice. R34 should have had a | a SCSA | |
| | Findings include: | | | completed after it was determine she would not return to her base performance. A significant chan | eline | |
| | 6/21/22, identified F | nimum Data Set (MDS) dated R34 had severe cognitive | | completed on December 1, 202 | 2. | |
| | _ | ignoses included femur | | 2. How the facility will identify | | |
| | | eplacement surgery, cognitive | | residents having the potential to | | |
| | | ficiency and heart disease. ent with transfers and | | affected by the same deficient page 4 Any residents who were hospital | | |
| | • | oom and required supervision | | receiving therapy services in the | | |
| | | rooming, dressing, toileting | | days will be reviewed for potenti | • | |
| | and ambulation in t | | | and complete as indicated. | | |
| | | | | 3. What measures will be put i | nto place, | |
| | • | 12/1/22, at 10:03 a.m. | | or systemic changes made, to e | | |
| | · · | RN)-B stated in September of | | the deficient practice will not rec | | |
| | • | Ill that resulted in a fracture | | will be re-educated on the Chap | | |
| | and R34 had signif | icant decline in ADL's | | pages 2-22 through 2-29 of the | | |
| | During interview on | 12/2/22, at 11:04 a.m. the | | manual as well as the Good Sar Policy and Procedure titled MDS | | |
| | • | (DON) stated staff complete a | | 4 under Procedure: Significant (| | |
| | • | MDS when a resident had two | | MDS. IDT will review residents | • | |
| | | esident was not expected to | | for potential SCSA at weekly Me | 0 | |
| | • | nanges. R34 had a fall with | | Meeting. Any resident on the ag | | |
| | fracture in Septeml | ber 2022, and upon return from | | high risk committee review will k | e | |
| | • | arted and completed physical | | considered weekly for SCSA. | | |
| | MDS should have b | stated a significant change been completed when R34 | | | | |
| | | erapy as R34 never returned | | 4. How the facility will monitor | | |
| | to baseline. | | | corrective actions to ensure that | | |
| | The facilities MADO | Docidant Accessors | | deficient practice is being correct | | |
| | | Resident Assessment olicy reviewed 6/6/22 identified | | will not recur. Any residents who hospitalized or receiving therapy | | |
| | ` . | e assessment should be | | will be audited for SCSA comple | , | |
| | · · | entification of the residents | | indicated 1 x per week x 4 week | | |
| | change. | | | month x 1 month, then monthly | • | |
| | | | | months. Results of audits will be | | |
| | The Minimum Data | Set 3.0 Manual V1.17.1 dated | | submitted to QAPI monthly x 3 t | | |
| | 10/19, identified as | sessment Management | | compliance and reassessed for | further | |

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| F 677 | Requirements and Status Assessment when: There is a dechange (either imported as indicatoresident current state comprehensive assequarterly assessment condition is not expendition is not expendition is not expendition is not expendition in the part of the pa | Tips for Significant Change in s: A SCSA is appropriate etermination that a significant rovement or decline) in a from his/her baseline has ed by comparison of the tus to the most recent sessment and any subsequent ents; and The resident's ected to return to baseline Guidelines for Determining a in Resident Status: The final titutes a significant change in ed upon the judgment of the ry team). MDS assessments minor or temporary variations in these cases, the resident's ed to return to baseline within er, staff must note these in the resident status in the end implement necessary planning, and clinical though an MDS assessment the Guidelines to Assist in ge is Significant or Not: ore of the following: Any hysical functioning area where coded as extensive pendence, or activity did not ontinence pattern changes or not of an indwelling catheter. For Dependent Residents 2) | F 637 | action. | | 1/17/23 |
| | | y living receives the necessary n good nutrition, grooming, and ygiene; | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | ` ' | E SURVEY PLETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 677 | by: Based on observative review, the facility of grooming and personal personal who we care. Findings include: R4's quarterly Minital 11/15/22, identified impairment and was personal hygiene at R4's care plan data required total assist incontinence care, maintain ADL functions. On 11/30/22, at 6:4 observed with nursonal NA-B. NA-A removed with nursonal NA-B. N | tion, interview and document failed to provide routine onal hygiene to 1 of 5 ewed for activities of daily living ere dependent on staff for their mum Data Set (MDS) dated R4 had severe cognitive as totally dependent on staff for and bathing. ed 10/10/22, identified R4 tance with grooming, and with a goal that R4 would ion with staff assistance. 5 a.m. R4's morning care was ing assistant (NA)-A and yed bed sheet and checked it was wet or soiled. She as dry and closed the brief. loset to obtain R4's clothing. R4 to dress and placed the lift him. They transferred R4 into mechanical lift. NA-A combed a put on his shoes. NA-A chair in front of the television, and to his shirt and exited the donot provide any partial bed | F 67 | 1. How corrective action will be accomplished for those residents have been affected by the deficie practice. R4 has expired due to currelated to deficiency. Residen care plan was reviewed prior to hassing and was appropriate for 2. How the facility will identify or residents having the potential to affected by the same deficient probirector of Nursing, Quality Specidesignee; will review all care plandependent residents to ensure adaily living are appropriately comand specific to resident. Each cawill include AM/PM care intervent perineal care, grooming and pershygiene which will flow to the point to guide nursing staff. Audits will completed by the Director of Nurdesignee to verify compliance. 3. What measures will be put intor systemic changes made, to enthe deficient practice will not recunursing staff will attend an in-sent educating them on activities of defocusing on what should be offered/completed for every resident morning and evening cares. Dire Nursing will create a generalized duties for AM/PM cares for all NA will be provided to current emplored. | found to ent conditions to ADL is his care. The actice ialist or is of ctivities of pleted re plantions, i.e., sonal into for care be sing or ito place, is all vice ally living, lent in the ctor of list of A-C. This yees and | |
| | stated they did not | do bed baths and only when the resident was | | a copy will be placed in our NA-C new hire packet. | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF A. BUILDING | PLE CONSTRUCTION 3 | COM | E SURVEY PLETED |
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| | 245318 | B. WING | | 1 | C 02/2022 |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - | INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | <u> </u> | |
| PREFIX (EACH DEFICIENCY | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| with morning cares of skin. That was all do day and it was not Red During interview on stated she assisted 12/2/22. NA-C assist using a warm basin liked the water slight partials and was fully care. She washed a peri area and applied R4 enjoyed his morn not think of a time how the word include washing area and was done or esident up for the digust on bath day. It was were not assist daily. During interview on director of nursing sidependent residents when assisting them found some of the nureminded of this and more training with the The facility policy Acreviewed 11/29/22, in the skin i | d not wash or dry resident or provide any lotion to their one on the resident's bath | F 67 | 4. How the facility will monitor it corrective actions to ensure that deficient practice is being correct will not recur. To monitor perform ensure that solutions are sustain Director of Nursing, Quality Spectosignee; will audit AM/PM groof personal care on 3 random deperesidents daily X2 weeks, 3X/we weeks, 1X/week for 4 weeks the month for 3 months until complia sustained. The results will be brothe monthly QAPI meeting for reand/or further recommendations | the ted and ance and ed the talist or ming and ndent ek for 2 nce is ought to view | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING | X3) DATE SURVEY COMPLETED | | |
|--|--|---|------------------------------|--|-----------------|
| | | 245318 | B. WING | | C 12/02/2022 |
| | PROVIDER OR SUPPLIER | - INTERNATIONAL FALLS | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 201 KEENAN DRIVE NTERNATIONAL FALLS, MN 56649 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | SE COMPLETION |
| F 688 | good nutrition, groot hygiene. ADLs are the the normal couincluded general personners. | age 6 oming and personal and oral necessary tasks conducted in rse of a resident's daily life and ersonal and daily hygiene and ecrease in ROM/Mobility | F 688 | | 1/17/23 |
| SS=D | resident who enters range of motion do range of motion un condition demonstr of motion is unavoided §483.25(c)(2) A resemble of motion receives appropriate assistance to main the maximum practiced reduction in mobility This REQUIREMENT. | facility must ensure that a the facility without limited es not experience reduction in less the resident's clinical rates that a reduction in range | | F688 | |
| | review the facility factor of 3 residents (Ramotion services. Findings include: R28's significant change (MDS) dated 11/28 | ailed to apply a hand splint for 28) reviewed for range of 22, identified severe cognitive as totally dependent on staff for | | How corrective action will be accomplished for those residents for have been affected by the deficient practice. Review of R28 care plan w completed for accuracy and clarification/education provided to st usage of hand splint. How the facility will identify other | as aff on |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION ING | l \ | E SURVEY PLETED |
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| | | 245318 | B. WING | | | C |
| | | 243310 | D. WING | | | 02/2022 |
| | PROVIDER OR SUPPLIER | INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP COD 2201 KEENAN DRIVE | E | |
| GOOD S | AWAKITAN SOCIETT | - INTERNATIONAL FALLS | | INTERNATIONAL FALLS, MN 5664 | 19 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | HOULD BE | (X5) COMPLETION DATE |
| F 688 | Continued From pa | age 7 | F 6 | 888 | | |
| | her activities of dai | ly living. R28 was identified to nursing program and utilized a | | residents having the potential affected by the same deficient residents using medical device potential to be affected. Direct | practice. All es have the | |
| | required assistance | ted 10/26/22, identified R28 e with a left resting hand splint. If resting hand splint all day and activities. | | Nursing and/or designee will a residents currently utilizing me equipment to maintain mobility. Physicians' orders will be review. | udit all edical and ROM. ewed for | |
| | identified R28 was | therapy noted dated 10/28/22, tolerating splint used for left nd no further changes were e. | | compliance to ensure all medi have the proper orders. Care reviewed to ensure all residen an assistive device to maintain ROM/Mobility is care planned | plans will be ts utilizing n | |
| | was sitting in her was area and her left ha | on 11/29/22, at 8:16 a.m. R28 heelchair in the living room and clenched and pulled up to not wearing a splint on her | | appropriately with detailed instruction on and taking off devices. 3. What measures will be put or systemic changes made, to the deficient practice will not reduce the deficient practice will not reduce the property and Robabilitation with the deficient practice. | e. t into place, ensure that ecur. visor of | |
| | nursing assist (NA) ready for the day. left hand laying acreleft hand was clend brace was on the tassisted R28 with lapply the left-hand room and obtained her left hand and o | on 11/30/22, at 6:56 a.m. P-E entered R28's to get R28 R28 was lying in bed with her coss her stomach and R28's ched. R28's resting hand able next to the bed. NA-E ner morning cares but did not splint. TMA-A entered the a blood sugar reading using nly moved the index finger | | Therapy and Rehabilitation win-service educating nursing serforming ROM including use implementation of assistive deeducation will detail the import following the therapy program Medicare meetings all resident care planned for ROM will be participation, program revision care plan updates. | taff on age and vices. The ance of the taken are the taken are the taken are reviewed for | |
| | TMA-A completed room and did not posservation was in the living rolleft hand was clend | he clenched hand. When the blood sugar she exited the ut the left-hand splint on. on 11/30/22, at 7:21 a.m. R28 om area watching TV and her shed and pulled up to her twearing the left-hand splint. | | 4. How the facility will monitor corrective actions to ensure the deficient practice is being correction will not recur. The Director of Quality Specialist or designee observation audits of 3 randor care planned for ROM to ensure | at the ected and Nursing, , to conduct n residents | |
| | | t remained on R28's table in | | participation revision and care | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , | TIPLE CONSTRUCTION ING | ` ′ | E SURVEY PLETED |
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| | | 245318 | B. WING | | | C 02/2022 |
| | PROVIDER OR SUPPLIER | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | - | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER) CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| | was in the living room not have the left-had During an interview stated R28 should for when eating. We splint on regularly, and difficult to straig the left-hand brace morning shift. NA-laready that morning left-hand brace and During an interview occupational therap assessed and found hand and was start program. A left-hand the range of motion R28 should wear the during meals and a her hand. The OT splint and after wor During an interview director of nursing swear a left-hand specific meals. It was ident would expect staff to The facility policy R 5/3/22, identified specific prevent and treater to prevent and treater to the state of the second staff to the s | on 12/2/22, at 9:08 a.m. R28 om area watching TV and did nd brace on. on 12/2/22, at 9:20 a.m. NA-E have always her brace, except hen R28 did not have the R28's hand can become stiff ghten out. R28 did not have when NA-E arrived for her E stated she got R28 up and and forgot to put on the should have. on 12/2/22, at 9:30 a.m. the bist (OT) stated R28 was d had a lot of tension in her left ed on a range of motion d splint was added because a program was not enough. The left-hand brace except for ctivities where she could use stated she forgot to place the king with R28 that morning. on 12/2/22, at 10:13 a.m. the stated R28 was supposed to lint at all times except for iffied in the care plan and to follow the care plan. destorative-Splinting dated blinting care be beneficial way to contractures. | F 6 | updates as needed. Daily x 2wee 3x/wk for 2 weeks, 1x/wk for 4 w 1x month x 3 months until compl sustained. The results will be brothe monthly QAPI meeting for reand/or further recommendations | eeks then ance is ught to view | |
| | Infection Prevention CFR(s): 483.80(a)(| | F 8 | 80 | | 1/17/23 |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | COM | E SURVEY PLETED |
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| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICITION DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 880 | infection prevention designed to provide comfortable environdevelopment and tradiseases and infection gram. The facility must estand control program a minimum, the following services arrangement based conducted accordinaccepted national services for the but are not limited to (i) A system of survices for the but are not limited to (ii) When and to who communicable diserported; (iii) Standard and trate to be followed to provide to provide the provide to provide the provide to the persons in the facili (iii) When and to who communicable diserported; (iii) Standard and trate to be followed to provide the provide to provide the provide to the provide the provide to the provid | control ctablish and maintain an and control program a safe, sanitary and ament and to help prevent the cansmission of communicable ctions. In prevention and control ctablish an infection prevention an (IPCP) that must include, at awing elements: Item for preventing, identifying, and controlling infections aliseases for all residents, actions, and other individuals aunder a contractual aupon the facility assessment ag to §483.70(e) and following attandards; en standards, policies, and program, which must include, accept can spread to other atty; and possible incidents of asse or infections should be ansmission-based precautions event spread of infections; isolation should be used for a | F 88 | 30 | | |

| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS (PAPER TAGE TAG (PA) ID (| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | | (X3) DATE SURVEY COMPLETED |
|--|--------|--|--|--------------------------|--|-------------------------------------|
| STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | | 245318 | B. WING _ | | |
| FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 10 (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 IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure mechanical lifts were disinfected between resident for 2 of 5 residents (R9, R15) observed to be transferred with mechanical lift. How corrective action will be accomplished for those residents found to have been affected by the deficient | | | | | 2201 KEENAN DRIVE | |
| (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 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 mechanical lifts were disinfected between resident for 2 of 5 residents (R9, R15) observed to be transferred with mechanical lift. How corrective action will be accomplished for those residents found to have been affected by the deficient | PRÉFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | BE COMPLETION |
| Findings include: R9's quarterly Minimum Data Set (MDS) dated 9/2/22, identified R9 had severe cognitive impairment with a diagnosis of Alzheimer's Island unit. During the Annual Survey, this item was identified with the RN Case manager as an item of concern. The RN Case Manager Immediately conducted staff education on her unit and placed | F 880 | (A) The type and depending upon the involved, and (B) A requirement least restrictive posticized circumstances. (v) The circumstant must prohibit emploisease or infected contact with reside contact will transmit (vi) The hand hygie by staff involved in §483.80(a)(4) A sylidentified under the corrective actions in §483.80(e) Linens Personnel must have transport linens so infection. §483.80(f) Annual The facility will contact the facility will contact the corrective actions in §483.80(f) Annual The facility will contact the facility facility for the facility facility for the facility facility for the facility facility facility facility for the facility fa | uration of the isolation, e infectious agent or organism that the isolation should be the ssible for the resident under the discessible for the resident under the discessible for the resident under the discessible for the resident under the discessions from direct ents or their food, if direct it the discess; and the procedures to be followed direct resident contact. In the discession of the discession o | | F880 1. How corrective action will be accomplished for those residents for have been affected by the deficient practice. R9 and R15 reside on Down Island unit. During the Annual Survitem was identified with the RN Case manager as an item of concern. The Case Manager Immediately conductives. | ey, this e e ne RN eted |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION ING | · / | E SURVEY IPLETED |
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| NAME OF F | PROVIDER OR SUPPLIER | <u>I</u> | 1 | STREET ADDRESS, CITY, STATE, ZIP C | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONAL FALLS | | 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 5 | 6649 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BE | (X5) COMPLETION DATE |
| F 880 | activities of daily live ambulate. R15's quarterly MER15 had moderate diagnosis of deme assistance with be and was unable to On 11/30/22, at 6:4 (NA)-F and NA-G versions. | otally dependent on staff for all ving and was unable to OS dated 11/14/22, identified ly impaired cognition with a ntia. R15 required staff d mobility, transfers, toilet use ambulate. 18 a.m. nursing assistant were observed using the total | F 8 | signage on the unit lifts to rethe requirement to clean me between each patient use. 2. How the facility will idented the residents having the potential affected by the same deficited All residents using the mechanism to be affected by the potential to | echanical lift Intify other ial to be ent practice. hanical lift ected by this put into place, | |
| | wheelchair. Upon NA-G pushed the troom and placed the hallway. NA-F and disinfect the lift after the hallway. During observation NA-G wheeled the R15's room. NA-F | ransfer R9 from the bed to the completion of the transfer, total mechanical lift out of R9's he lift up against the wall in the I NA-G were not observed to er use and prior to leaving it in same total mechanical lift into and NA-G used the same lift in the bed to the wheelchair. | | or systemic changes made the deficient practice will no Cause Analysis was conducted 12/28/22 per the DPOC. It education with staff were id through this process. Staff were developed. Staff educted competency evaluation will for all clinical staff who are the mechanical lift. | t recur. Root cted on ems for entified competencies cation and be provided trained to use | |
| | stated she had not mechanical lift after transferring R15. I mechanical lift was disinfiected between During interview or stated the total medisincected after transferring R15. During interview or transferring R15. | n 11/30/22, at 7:19 a.m. NA-G disinfected the total or transferring R9 and prior to NA-G stated the same total sused without being en the two residents. n 11/30/22, at 7:22 a.m. NA-F chanical lift was not ansferring R9 or prior to ansferring R9 or prior to hurse (LPN)-A stated staff were | | 4. How the facility will more corrective actions to ensure deficient practice is being consulted will not recur. Audits of statemechanical lift equipment we conducted by DON or Qualification or designee. Audits conducted on 3 random depresidents daily X2 weeks, 3 weeks, 1X/week for 4 week month for 3 months until consustained. The results will be the monthly QAPI meeting and/or further recommendations. | e that the orrected and ff cleaning will be ity Specialist will be pendent of the for 2 mpliance is be brought to for review | |

| _ ` | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l `´´ | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---------------------|--|-------------------------------|----------------------------|
| | | 245318 | B. WING | | 1 | C 2/02/2022 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP C 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 5 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 880 | and it was not apprehan one resident was uses. During interview on registered nurse (Rowere to be disinfect should not use the another without disinfect were aware of the example of the example of the example of the spread of | chanical lifts after each use opriate to use the lift on more without cleaning in between 11/30/22, at 7:48 a.m. N)-B stated mechanical lifts eed after every use and staff lift from one resident to infecting it between uses. Staff | F 8 | 80 | | |



Electronically delivered December 21, 2022

Administrator Good Samaritan Society - International Falls 2201 Keenan Drive International Falls, MN 56649

Re: State Nursing Home Licensing Orders

Event ID: ZQNK11

Dear Administrator:

The above facility was surveyed on November 28, 2022 through December 2, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 <u>only a suggestion</u> 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

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

Office: (218) 308-2104 Mobile: (218) 368-3683

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumala Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ` ′ | E CONSTRUCTION | l ` ′ | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|--|---------------------|---|-------------------------------|--------------------------|--|
| | | 00322 | | B. WING | | | C 12/02/2022 | |
| NAME OF I | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | 2201 KEE | NAN DRIVE | | | | |
| | | | | TIONAL FAL | LS, MN 56649 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT | ULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE | |
| 2 000 | Initial Comments | | | 2 000 | | | | |
| | *****ATTE | NTION***** | | | | | | |
| | NH LICENSING | CORRECTION ORDI | ER | | | | | |
| | 144A.10, this correct pursuant to a surve found that the defication herein are not corrected shall be a surved and corrected shall be a surved as a surved and the surved are not corrected. | Minnesota Statute, section order has been in the section of the se | issued on, it is cited violation dance | | | | | |
| | 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. | | | | | | | |
| | that may result from orders provided that the Department with | hearing on any asses non-compliance with t a written request is none of the compliance nt for non-compliance | n these made to of a | | | | | |
| | survey was conduct by surveyors from the Health (MDH). Your compliance with the indicate in your elec- | S: 12/2/22, a standard I ted completed at your he Minnesota Departi facility was found NO the MN State Licensure these orders, and ide | r facility ment of DT in . Please ion that | | | | | |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

12/30/22

(X6) DATE

Minnesota Department of Health

| | TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ´ | E CONSTRUCTION | . , | (X3) DATE SURVEY COMPLETED | |
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| | | 00322 | B. WING | | | C 02/2022 | |
| | PROVIDER OR SUPPLIER | - INTERNATIONA 2201 KE | DDRESS, CITY, S ENAN DRIVE ATIONAL FALI | TATE, ZIP CODE S, MN 56649 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | |
| 2 000 | Continued From pa | ge 1 | 2 000 | | | | |
| | date when they will | be completed. | | | | | |
| | was found to be SU | laint H53186033C (MN87700) IBSTANTIATED; however, no Ited due to actions taken by | | | | | |
| | The following comp UNSUBSTANTIATE H53185928C (MN8 H53185929C (MN8 H53186026C (MN8 H53186027C (MN8 H53186029C (MN8 H53186030C (MN8 H53186031C (MN8 H53186031C (MN8 H53186032C (MN8 | 7574) 9875) 5414) 6687) 6440) 5379) 5250) 5252) | | | | | |
| | the State Licensing Federal software. To assigned to Minnes Nursing Homes. The appears in the far leading." The state state listed in the "Summ column and replace the correction order the findings which a statute after the state as evidence by." For a state of the | correction Orders using ag numbers have been ota state statutes/rules for e assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies as the "To Comply" portion of This column also includes are in violation of the state tement, "This Rule is not met ollowing the surveyor's aggested Method of Correction of Correction. | | | | | |
| | receipt of State lice the Minnesota Depart | participate in the electronic nsure orders consistent with artment of Health in 14-01, available at | | | | | |

Minnesota Department of Health

STATE FORM ZQNK11 If continuation sheet 2 of 14

Minnesota Department of Health

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--|------------------------------|--|-------------------------------|--------------------------|
| | | 00322 | | B. WING | | C 12/02/2022 | |
| NAME OF F | PROVIDER OR SUPPLIER | | TREET ADI | DRESS CITY S | STATE, ZIP CODE | 1 2/0 | |
| | | 2 | | NAN DRIVE | TATE, ZII CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NTERNAT | TONAL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INCOMPAGE OF THE APPROPERT | D BE | (X5) COMPLETE DATE |
| 2 000 | Continued From pa | ge 2 | | 2 000 | | | |
| | http://www.health.st obul.htm. The State delineated on the at Department of Heal you electronically. It is necessary for State enter the word "CO available for text. You electronic State lice heading completion be corrected prior to the Minnesota Depais is enrolled in ePOC not required at the It state form. PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE | tate.mn.us/divs/fpc/proferice licensing orders are stached Minnesota of the orders being submitted though no plan of constant of RECTED" in the box of must then indicate in the sure process, under the date, the date your order the date, the date your order the artment of Health. The land therefore a signation of the first page of the RECTED of the first page. | ted to rection se the ders will ng to facility ure is of | | | | |
| 2 545 | MN Rule 4658.0400 Resident Assessme | Subp. 3 A-C Comprehent; Frequency | nensive | 2 545 | | | 1/17/23 |
| | assessments must A. within 14 day B. within 14 day the resident's physic | be conducted: s after the date of admirs after a significant character or mental condition; every 12 months. | ission; ange in | | | | |
| | by: Based on interview facility failed to review significant change in | ent is not met as evide and document review, ew for and/or complete n status assessment (S areas of change in resid | the a SCSA) | | Corrected | | |

Minnesota Department of Health

STATE FORM ZQNK11 If continuation sheet 3 of 14

Minnesota Department of Health

| | MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | E CONSTRUCTION | · , , | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|--|---------------------|---|------------------------------------|--------------------------|
| | | 00322 | | B. WING | | | C 02/2022 |
| | ROVIDER OR SUPPLIER | - INTERNATIONA | 2201 KEE | NAN DRIVE | STATE, ZIP CODE LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM | ' FULL | ID PREFIX TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| | reviewed for activities. Findings include: R34's quarterly Minite 6/21/22, identified Finding impairment and diagracture with joint recommunication defied ambulation in the rewith bed mobility, grand ambulation in the polymer of ambulation in the resistered nurse (R2022, R34 had a fall and R34 had significant change for a facture in Septemble the hospital R34 states therapy. The DON MDS should have be finished physical the to baseline. The facilities MDS Finstrument (RAI) polymer in the polymer | ed for 1 of 5 resident es of daily living. imum Data Set (MD 834 had severe cogr gnoses included fen eplacement surgery, ciency and heart dis ent with transfers and om and required su rooming, dressing, to | S) dated nitive nur cognitive sease. dipervision oileting m. ember of racture s m. the omplete and two cted to fall with return from physical change in R34 returned of the control of the | 2 545 | | | |
| | | Set 3.0 Manual V1. | | | | | |

Minnesota Department of Health

| | TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | E CONSTRUCTION | · · · · | (X3) DATE SURVEY COMPLETED | |
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| | | 00322 | | B. WING | _ | | C 02/2022 |
| | PROVIDER OR SUPPLIER | - INTERNATIONA | 2201 KEE | NAN DRIVE | TATE, ZIP CODE LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY SC IDENTIFYING INFORM | Y FULL | ID PREFIX TAG | PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETE DATE |
| 2 545 | Requirements and Status Assessment when: There is a dechange (either impresident's condition occurred as indicate resident current state comprehensive assequarterly assessment condition is not expedition what consistatus must be based IDT (interdisciplinar are not required for in resident status — condition is expected two weeks. However transient changes in resident's record and assessment, care printerventions, even is not required. Some Deciding If a Change Decline in two or modecline in an ADL proceding If a Change Decline in two or modecline in two or modecline in an ADL proceding If a Change Decline in two or modecline in two or mod | Tips for Significant of Significant | criate significant in a ne has fethe ent ubsequent ent's aseline mining a The final change in the saments variations resident's ine within nese in the sary I sessment sist in lot: Any area where y did not hanges or atheter. TION: The ise policies nificant ald be ce of essments. | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ` ' | | | (X3) DATE SURVEY COMPLETED | |
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| ANDILAN | OF CORRECTION | IDENTIFICATION NO | NIDEIX. | A. BUILDING: | | | |
| | | 00322 | | B. WING | | | 2/ 2022 |
| NAME OF I | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | 2201 KEE | NAN DRIVE | | | |
| | AMARTANOOOLIT | | INTERNA | ΓΙΟΝΑL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 545 | Continued From pa | ge 5 | | 2 545 | | | |
| | TIME PERIOD FOR CORRECTION: Twenty one (21) days. | | | | | | |
| 2 890 | MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion | | | 2 890 | | | 1/17/23 |
| | Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is | | | | | | |
| | This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to apply a hand splint for 1 of 3 residents (R28) reviewed for range of motion services. | | | | Corrected | | |
| | Findings include: | | | | | | |
| | (MDS) dated 11/28/ impairment and wa her activities of dail | ange Minimum Data /22, identified severe s totally dependent of y living. R28 was ide nursing program and | e cognitive on staff for entified to | | | | |

Minnesota Department of Health

| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | E CONSTRUCTION | . , | (X3) DATE SURVEY COMPLETED | | |
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| | | 00322 | | B. WING | | | C 02/2022 | |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| GOOD S | AMARITAN SOCIETY | INTEDNATIONA | 2201 KEE | NAN DRIVE | | | | |
| | AWARITAN SOCILIT | | INTERNA | TIONAL FAL | LS, MN 56649 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCE MUST BE PRECEDED B SC IDENTIFYING INFORM | Y FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | |
| 2 890 | Continued From page | ge 6 | | 2 890 | | | | |
| | R28's care plan data required assistance R28 was to wear left besides mealtime at R28's occupational identified R28 was thand positioning an required at this time. During observation was sitting in her wharea and her left hand her chest. R28 was left hand. | with a left resting hat resting hand splin nd activities. therapy noted date olerating splint used no further change heelchair in the living and clenched and pend clenched and pend clenched and pend the living and clenched and pend the living are living as living and clenched and pend the living are living as living and clenched and pend the living are living as liv | hand splint. It all day d 10/28/22, d for left es were 6 a.m. R28 ng room ulled up to | | | | | |
| | During observation nursing assist (NA)-ready for the day. Fleft hand laying acrolleft hand was clenched brace was on the taleassisted R28 with happly the left-hand stroom and obtained her left hand and or about 1 inch from the TMA-A completed froom and did not puring observation was in the living roolleft hand was clenchest. R28 was not The left-hand splint her room. | E entered R28's to R28 was lying in beats her stomach and hed. R28's resting able next to the beds er morning cares be splint. TMA-A enter a blood sugar read ally moved the index he clenched hand. The blood sugar shout the left-hand splint on 11/30/22, at 7:20 m area watching Thed and pulled up to wearing the left-hard remained on R28's remained on R28's second results. | get R28 d with her d R28's hand NA-E ut did not ed the ing using finger When e exited the nt on. 1 a.m. R28 V and her o her nd splint. stable in | | | | | |
| | During observation was in the living roo | | | | | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | ` / | | CONSTRUCTION | ` ′ | (X3) DATE SURVEY COMPLETED | |
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| | 00322 | B. WING | | | C 02/2022 | |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY | - INTERNATIONA 2201 KEE | DRESS, CITY, STAN DRIVE | TATE, ZIP CODE S, MN 56649 | | | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | |
| stated R28 should if for when eating. With splint on regularly, if and difficult to straig the left-hand brace morning shift. NA-E ready that morning left-hand brace and During an interview occupational therap assessed and found hand and was starte program. A left-hand the range of motion R28 should wear the during meals and acher hand. The OT splint and after world During an interview director of nursing (supposed to wear a except for meals. It plan and would expend plan. The facility policy R 5/3/22, identified specified specif | on 12/2/22, at 9:20 a.m. NA-E have always her brace, except hen R28 did not have the R28's hand can become stiff ghten out. R28 did not have when NA-E arrived for her E stated she got R28 up and and forgot to put on the should have. on 12/2/22, at 9:30 a.m. the hist (OT) stated R28 was did had a lot of tension in her lefted on a range of motion did splint was added because program was not enough. The lefter eleft eleft hand brace except for civities where she could use stated she forgot to place the king with R28 that morning. on 12/2/22, at 10:13 a.m. the DON) stated R28 was a left-hand splint at all times the was identified in the care ect staff to follow the care estorative-Splinting dated linting care be beneficial way | | | | | |

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| | IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER: | | | 1 ` ' | | | DATE SURVEY COMPLETED | |
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| | | 00322 | | B. WING | | 12/0 |) 2/2022 | |
| | PROVIDER OR SUPPLIER | - INTERNATIONA | 2201 KEE | NAN DRIVE | STATE, ZIP CODE LS, MN 56649 | | | |
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| 2 890 | Continued From page | | ad and | 2 890 | | | | |
| | care planned. The | emented as assesse quality assessment a ee could perform rar mpliance. | and | | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Tw | venty-one | | | | | |
| 2 920 | MN Rule 4658.0525 | Subp. 6 B Rehab - | - ADLs | 2 920 | | | 1/17/23 | |
| | comprehensive resine home must ensure B. a resident who activities of daily livi | is unable to carry oung receives the necessity of the nec | nursing ut essary | | | | | |
| | by: Based on observation review, the facility fa | ent is not met as evion, interview and do ailed to provide routing all hygiene to 1 of the wed for activities of the dependent on sta | cument ne 5 daily living | | Corrected | | | |
| | Findings include: | | | | | | | |
| | 11/15/22, identified | num Data Set (MDS) R4 had severe cogn s totally dependent of nd bathing. | itive | | | | | |
| | required total assist incontinence care, v | d 10/10/22, identified ance with grooming, with a goal that R4 w on with staff assistar | , and <i>r</i> ould | | | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | ` ' | | CONSTRUCTION | 1 ` ′ | (X3) DATE SURVEY COMPLETED | |
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| | 00322 | B. WING | | | C 02/2022 | |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY | - INTERNATIONA 2201 KEE | NAN DRIVE | TATE, ZIP CODE S, MN 56649 | | | |
| PREFIX (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC) | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | |
| observed with nurs NA-B. NA-A remove R4's brief to see if it stated R4's brief was NA-A went to the composition of the R4's hair and NA-Beturned R4's wheel a secured his call light room. The NA's distant or peri care. When interviewed stated they did not provided peri care incontinent. They owith morning cares skin. That was alled ay and it was not During interview or stated she assisted 12/2/22. NA-C assit using a warm basin liked the water sligh partials and was fucare. She washed peri area and applier R4 enjoyed his morn of think of a time of the R4 senjoyed practical interviewed licensed practical interviewe | 5 a.m. R4's morning care was ing assistant (NA)-A and yed bed sheet and checked it was wet or soiled. She as dry and closed the brief. loset to obtain R4's clothing. R4 to dress and placed the lift him. They transferred R4 into mechanical lift. NA-A combed is put on his shoes. NA-A chair in front of the television, at to his shirt and exited the dinot provide any partial bed on 11/30/22, at 7:00 a.m. NA-A do bed baths and only when the resident was did not wash or dry resident or provide any lotion to their done on the resident's bath R4's bath day. 12/2/22, at 9:00 a.m. NA-C I R4 to get up the morning of sted R4 with a partial bath, and warm soapy water. R4 antly soapy with his morning and dried his torso, back and led lotion to his back. She felt raing partials and she could he ever refused it or resisted it. | | | | | |
| | up for the day. A partial bath ning a residents back and peri | | | | | |

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Minnesota Department of Health

| | IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | ` ′ | (X3) DATE SURVEY COMPLETED | |
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| | | 00322 | | B. WING | | 12/0 |) 2/2022 |
| | OVIDER OR SUPPLIER | - INTERNATIONA | 2201 KEE | NAN DRIVE | STATE, ZIP CODE LS, MN 56649 | | |
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| are jund Ddid w forem Tre w w ghith in g SD read thide T | esident up for the oust on bath day. It last on bath day. Ouring interview on irector of nursing sependent residents when assisting then bund some of the reminded of this and nore training with the facility policy Activities of the normal councluded general personning. SUGGESTED METOON or designee could educe policies and processione could educe policies and processione could deven sure ongoing consure on | daily when getting the day. It was done daily would be a concernating residents with a stated she expected as to receive a partial in to get up for the daily newer NA's needed to she was planning onem regarding the isocitivities of Daily Living identified any resident out activities of daily ssary services to make ming and personal and personal and personal and daily hygist stated and daily hygist stated she was planning of the day of t | and not if the partial on. the all bath y. She on doing sue. got who living intain aducted in its life and lene and or all Norestaff on restaff on restaf | 2 920 | | | |
| _ | IN Rule 4658.0800 rogram | Subp. 1 Infection C | ontrol; | 21375 | | | 1/17/23 |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | 1 ` ′ | (X3) DATE SURVEY COMPLETED | |
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| | | | | С | | |
| | | 00322 | B. WING | 12/02 | 2/2022 | |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONA 2201 F | ADDRESS, CITY, STATE, ZIP CODE KEENAN DRIVE NATIONAL FALLS, MN 56649 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN CORRECTIVE ACCURATE CROSS-REFERENCED TO DEFICIENT | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETE DATE | |
| 21375 | Continued From page 11 | | 21375 | | | |
| | home must establis | on control program. A nursing the and maintain an infection signed to provide a safe and the nt. | | | | |
| | This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure mechanical lifts were disinfected between resident for 2 of 5 residents (R9, R15) observed to be transferred with mechanical lift. | | Corrected | | | |
| | Findings include: | | | | | |
| | 9/2/22, identified R9 impairment with a disease. R9 was to | num Data Set (MDS) dated had severe cognitive liagnosis of Alzheimer's tally dependent on staff for a ing and was unable to | | | | |
| | R15 had moderated diagnosis of demen | S dated 11/14/22, identified y impaired cognition with a tia. R15 required staff mobility, transfers, toilet us ambulate. | e | | | |
| | (NA)-F and NA-G we mechanical lift to transverse wheelchair. Upon on NA-G pushed the to room and placed the hallway. NA-F and disinfect the lift after the hallway. | 8 a.m. nursing assistant vere observed using the total ansfer R9 from the bed to the completion of the transfer, otal mechanical lift out of R9 e lift up against the wall in the NA-G were not observed to r use and prior to leaving it is | e 's ne | | | |
| | During observation | on 11/30/22, at 7:03 a.m. | | | | |

Minnesota Department of Health

STATE FORM ZQNK11 If continuation sheet 12 of 14

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ´ | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | 00322 | B. WING | | | C 02/2022 | | |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONA STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | | | | | | |
| PREFIX (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | | |
| During interview stated she had a mechanical lift a transferring R15 mechanical lift with disinflected between the total and disincected after transferring R15. During interview licensed practicated the total and it was not a than one residences. During interview registered nurses were to be dising should not use the another without were aware of the transferring R15. During interview registered nurses were to be dising should not use the another without were aware of the transferring R15. The facilities San Competency Valirected staff to the total and the total another without to prevent the san the facilities San Competency Valirected staff to the transfer R15. | he same total mechanical lift into A-F and NA-G used the same lift from the bed to the wheelchair. on 11/30/22, at 7:19 a.m. NA-G not disinfected the total fiter transferring R9 and prior to . NA-G stated the same total was used without being ween the two residents. on 11/30/22, at 7:22 a.m. NA-F mechanical lift was not ransferring R9 or prior to . on 11/30/22, at 7:23 a.m. all nurse (LPN)-A stated staff we nechanical lifts after each use opropriate to use the lift on mornt without cleaning in between on 11/30/22, at 7:48 a.m. (RN)-B stated mechanical lifts fected after every use and staff the lift from one resident to disinfecting it between uses. State expectation. on 12/2/22, at 11:49 a.m. the ng (DON) stated direct care lid be disinfected after each use oread of potential infection. fe Resident Handling Equipmer idation Checklist, dated 11/21, clean mechanical lifts after use | ere e aff | | | | | |
| SUGGESTED N | IETHOD FOR CORRECTION: | | | | | | |

Minnesota Department of Health

STATE FORM ZQNK11 If continuation sheet 13 of 14

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | | | | | | |
|--|--|--|--|-------------------------------|--------------------------|--|--|--|--|--|--|
| | | A. BUILDING. | | C | | | | | | | |
| | 00322 | B. WING | | 12/02/2 | 2022 | | | | | | |
| NAME OF PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | | | | | | | |
| GOOD SAMARITAN SOCIETY - INTERNATIONA 2201 KEENAN DRIVE | | | | | | | | | | | |
| | | | LS, MN 56649 | ON | 0.45) | | | | | | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | DBE C | (X5) COMPLETE DATE | | | | | | |
| 21375 Continued From page | ge 13 | 21375 | | | | | | | | | |
| The DON and/or dedevelop policies and regarding disinfect educes to prevent the substitution of the DON/ designeed equipment was disinfected and procedures. The the QAPI committeed recommendations of changes in the plant | signee could review and/or d provide education for staff equipment between resident pread of potential infections. It could audit staff to ensure enfected according to policies e audits could be brought to be for further review and on continued auditing or | 21375 | | | | | | | | | |

F5318033

PRINTED: 01/18/2023 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | | E CONSTRUCTION 03 - 2013 BUILDING | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--------------------|------------------------------------|---|------|----------------------------|
| | | 245318 | B. WING | | | 11/2 | 29/2022 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 201 KEENAN DRIVE NTERNATIONAL FALLS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 000 | INITIAL COMMEN | ΓS | K | 000 | | | |
| | FIRE SAFETY | | | | | | |
| | conducted by the Management of the National Public Safety, State 11/29/2022. At the Samaritan Society-not in compliance was participation in Med Subpart 483.70(a), 2012 edition of National Association (NFPA) Chapter 19 Existing edition of NFPA 99, THE FACILITY'S PALLEGATION OF COMPARTMENT'S ASIGNATURE AT THE PAGE OF THE CMUSED AS VERIFICATION FOR SUBSTANTIAL CORRECTIONS HAACCORDANCE WAS PLEASE RETURN CORRECTION FOR DEFICIENCIES (KAIFFICIENCIES (KAIFFICIES (KAIFFICIES (KAIFFICIES (KAIFFICIES (KAIFFICIES (KAIFFICIES (KAIFFICIES (KAIFFICIE | MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. THE PLAN OF R THE FIRE SAFETY TAGS) TO: IN THE E-POC PROCESS, A THE PLAN OF CORRECTION | | | | | |
| ABORATORY | DIRECTOR'S OR PROVID | DER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | | TITLE | | (X6) DATE |
| Electron | ically Signed | | | | | | 01/03/2023 |

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.

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - 2013 BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--|---|---------|-------------------------------|--|
| | | 245318 | B. WING | <u> </u> | 11 | /29/2022 | |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | OULD BE | (X5) COMPLETION DATE | |
| K 000 | DEFICIENCY MUS FOLLOWING INFO 1. A detailed described taken or planned to a sure the sustained to a sustained. 2. Address the metaplace to ensure the sustained. 4. Identify who is actions and monitor a sustained. 5. The actual or puthe remedy. The Good Samarita a new 1-story building to be Tybuilding is separate building with a 2-hours and the sustained to be Tybuilding with a 2-hours and the suilding with a 2-hours and suilding with a 2-hours and suilding with a 2-hours and suilding is fully accordance with NF Installation of Spring with quick response. | pections Division Suite 145 -5145, OR @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: ription of the corrective action correct the deficiency. easures that will be put in deficiency does not reoccur. e facility plans to monitor to ensure solutions are responsible for the corrective ring of compliance. roposed date for completion of an Society International Falls is ng, no basement, and was yee V (111) construction. The ed from the new assisted living | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l `´ | PLE CONSTRUCTION 3 03 - 2013 BUILDING | ` ′ | E SURVEY IPLETED |
|--|--|---|---------------------|---|------|----------------------------|
| | | 245318 | B. WING | | 11/ | 29/2022 |
| | PROVIDER OR SUPPLIER | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | . • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| K 324 | the corridors and a in all sleeping room installed in accordance. National Fire Alarm. The building is divided to compartments by 1 2-hour fire barriers. The facility has a carcensus of 43 at the total the total to | smoke detectors throughout reas open to the corridor and is that is monitored that is not with NFPA 72 "The Code" (2010 edition). ded into 3 smoke -hour smoke barriers and etime of the survey. at 42 CFR, Subpart 483.70(a), | K 000 | | | 1/17/23 |
| | with NFPA 96, Standard Fire Protection Operations, unless residential cooking appliances such as toasters) are used cooking in accorda cooking in accorda cooking facilities of compartments with with the conditions or cooking facilities is 30 or fewer patients 18.3.2.5.4, 19.3.2.5.4 Cooking facilities per 9.2.3 are not residents. | g equipment (i.e., small microwaves, hot plates, for food warming or limited nce with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3, n smoke compartments with a comply with conditions under | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER | | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - 2013 BUILDING (X3) DAT | | |
|---|--|--|--|--|---|
| | 245318 | B. WING | | 11/2 | 29/2022 |
| | | | 2201 KEENAN DRIVE | | |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | | χ (EACH CORRECTIVE ACTION | SHOULD BE | (X5) COMPLETION DATE |
| 18.3.2.5.1 through 19.3.2.5.5, 9.2.3, This REQUIREME by: | 18.3.2.5.4, 19.3.2.5.1 through TIA 12-2 | K3 | | | |
| interview, the facilic kitchen hood ventile system per NFPA Code, section 9.2.3 Standard for Ventile Protection of Compaction 11.2.1. This an isolated impact facility. Findings Include: On 11/29/2022, be was revealed by a documentation that the kitchen hood very system was not averaged provide completed for semi-annual kit inspections for the An interview with the complex compact of the complex complex compact of the complex complex complex compact of the complex compact of the complex compact of the compact | ty failed to test and inspect the ation and fire suppression 101 (2012 edition), Life Safety 3 and NFPA 96 (2011 edition), ation Control and Fire mercial Cooking Operations, a deficient finding could have on the residents within the times to available to the facility could not test/inspection documentation and fire suppression ailable. The facility could not test/inspection documentation chen hood suppression system last six (6) months. | | suppression system complet 1. Detailed description of the action taken or planned to condeficiency The facility is all documentation to support the of the inspection of the kitcher ventilation and fire suppression conducted on 8/23/2022 by 1/2. Address the measures the in place to ensure the deficient reoccur. The Maintenance create a Life Safety Code (Livith all documents required during a Life Safety Code instensure all documents are pretime of inspection. Each tabe the frequency required for each quick reference for any staff ensure completion. 3. Indicate how the facility promotion future performance is solutions are sustained. The Maintenance Director will british binder to the monthly QAPI of meetings for committee reviews assurance of completion. 4. Identify who is responsible corrective actions and monit | tion ne corrective orrect the ole to produce e completion en hood ion system LVC. hat will be put ency does not Director will SC) binder for review spection to epared at the will indicate ach task as a member to plans to to ensure ne ng the LSC Committee ew and ple for oring | |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY SUMMARY STA (EACH DEFICIENC REGULATORY OR I Continued From pa 18.3.2.5.1 through 19.3.2.5.5, 9.2.3, T This REQUIREME by: Based on docume interview, the facilit kitchen hood ventil system per NFPA Code, section 9.2.3 Standard for Ventil Protection of Commisection 11.2.1. This an isolated impact facility. Findings Include: On 11/29/2022, betwas revealed by a documentation that the kitchen hood very system was not av provide completed for semi-annual kit inspections for the An interview with the verified this deficie | PROVIDER OR SUPPLIER AMARITAN SOCIETY - INTERNATIONAL FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 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 documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 11/29/2022, between 10:30am and 1:30pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for semi-annual kitchen hood suppression system inspections for the last six (6) months. An interview with the Maintenance Director verified this deficient finding at the time of | PROVIDER OR SUPPLIER AMARITAN SOCIETY - INTERNATIONAL FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 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 documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 11/29/2022, between 10:30am and 1:30pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for semi-annual kitchen hood suppression system inspections for the last six (6) months. An interview with the Maintenance Director verified this deficient finding at the time of | PROVIDER OR SUPPLIER AMARITAN SOCIETY - INTERNATIONAL FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION). Continued From page 3 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 documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system or Occumentation of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 11/29/2022, between 10:30am and 1:30pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for the kitchen hood suppression system inspections for the last six (6) months. An interview with the Maintenance Director verified this deficient finding at the time of discovery. | PROVIDER OR SUPPLIER 245318 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILS TE PRECEDED BY PLL. REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 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 documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventiliation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Life Safety Code, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. On 11/29/2022, between 10:30am and 1:30pm, it was revealed by a review of available cocumentation that inspection documentation that inspection documentation that inspection documentation to support the completion of the safety Code (LSC) binder with all documents required for review during a Life Safety Code (LSC) binder with all documents required for review during a Life Safety Code inspection to ensure a ducine that how the facility plans to monitor future performance to ensure solutions are sustained — The Maintenance Director will bring the LSC binder to the monitor future performance to ensure solutions are sustained — The Maintenance Director will bring the LSC binder to the monitor future performance to ensure solutions are sustained — The Maintenance Director will bring the LSC binder to the monitor future performance to ensure solutions are sustained — The Maintenance Director will bring the LSC binder to the monitor future performance to ensure solutions are sustained — The Maintenance Director will bring the LSC binder to the monitor future performance to ensure solutions are sustained — The Maintenance Director will bring the LSC binder to the monitor future performance to ensure solutions are sustained — The Maintenance Director will bring the LSC bi |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l `´ | LE CONSTRUCTION 3 03 - 2013 BUILDING | l \ | E SURVEY IPLETED |
|---|--|---|---------------------|--|---|----------------------------|
| | | 245318 | B. WING | | 11/ | 29/2022 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE NTERNATIONAL FALLS, MN 5664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPOPULATION DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| K 324 | Continued From pa | ge 4 | K 324 | binder and for presenting comp Kitchen Hood Inspection Report QAPI committee. 5. Actual or proposed date for completion of remedy - January 2023. | rts to the r | |
| | Portable Fire Exting Portable fire extinguishers. 18.3.5.12, 19.3.5.12 | guishers uishers are selected, installed, ntained in accordance with for Portable Fire | K 355 | | | 1/17/23 |
| | Based on a review and staff interview, access to portable 101 (2012 edition), 9.7.4.1, and NFPA Portable Fire Exting This deficient finding impact on the residual Findings include: On 11/29/2022 between the standard or the residual fire extinguishers and documentation could have the standard or the review with Management at the standard or the sta | • | | K 355 □ Portable Fire Extinguit 1. Detailed description of the action taken or planned to corredeficiency □ The facility is able documentation to support the of Fire Extinguisher inspection units as of August, 2022 completed. 2. Address the measures that in place to ensure the deficient reoccur □ The facility has request the most recent and all future free extinguisher inspections be does by the contractor in a report preend of the inspection with the frand credentials of the contractor conducting the inspection. The will be kept in the LSC binder from the conduction of the contractor in the contractor in the contractor conducting the inspection. The will be kept in the LSC binder from the conduction of the contractor conduction of | corrective ect the to produce completion of facility leted by t will be put ested that ire cumented ovided the full name or ese reports or | |

| · · · · · · · · · · · · · · · · · · · | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION IG 03 - 2013 BUILDING | (X3) DATE SURVEY COMPLETED | |
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| | | 245318 | B. WING _ | | 11/29 | 9/2022 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 372 | Subdivision of Build CFR(s): NFPA 101 | ge 5 ling Spaces - Smoke Barrie | K 35 | monitor future performance to ensusolutions are sustained - The Maintenance Director will bring the binder to the monthly QAPI Commitmeetings for committee review and assurance of completion. 4. Identify who is responsible for corrective actions and monitoring compliance - The Maintenance Director responsible for development of the binder and for presenting complete Extinguisher Inspection Reports to QAPI committee. 5. Actual or proposed date for completion of remedy - January 17 2023. | LSC ttee LSC d Fire the | /17/23 |
| | Subdivision of Build Construction 2012 EXISTING Smoke barriers shafire resistance rating be permitted to term Smoke dampers are penetrations in fully an approved sprink smoke compartments barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechaning REMARKS. This REQUIREMENTS by: Based on observation facility failed to main | ding Spaces - Smoke Barrier all be constructed to a 1/2-hour g per 8.5. Smoke barriers shall minate at an atrium wall. e not required in duct ducted HVAC systems where ler system is installed for nts adjacent to the smoke anical smoke control system NT is not met as evidenced tion and staff interview, the ntain smoke barriers per NFPA Life Safety Code, sections | | K 372 □ Smoke Barrier Penetratio 1. Detailed description of the corraction taken or planned to correct t | ective | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l `´ | LE CONSTRUCTION 3 03 - 2013 BUILDING | (X3) DATE | SURVEY |
|--|---|---------------------|--|--|----------------------------|
| | 245318 | B. WING | | 11/2 | 9/2022 |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - | INTERNATIONAL FALLS | : | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE NTERNATIONAL FALLS, MN 56649 | | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| deficient findings coon the residents with Findings include: 1. On 11/29/2022 be pm, it was revealed a penetration runnin compartment to ano Dove Island, Voyage Cottage. 2. On 11/29/2022 be pm, it was revealed a penetration in a rakeeping closet in the An interview with Marketing contacts. | .5.2.2, and 8.5.6.5. These uld have a widespread impact nin the facility. etween 10:30 am and 1:30 by observation that there was | K 372 | deficiency - Penetration running from smoke compartment to another all doors leading to each unit and the Kempton Cottage Housekeeping of will be caulked with fire rated material maintain the integrity of the smoke compartment for each area. 2. Address the measures that will in place to ensure the deficiency director - Maintenance Director will implement an Above Ceiling Permitequirement for any contractor who working above the ceiling. This requirement will alert the contractor identify and caulk any areas of smocompartment penetration as part of expectation for work completion. A areas identified will be inspected by Maintenance Director and the Conformutual agreement that work is complete. 3. Indicate how the facility plans to monitor future performance to ensistency and it follows a solutions are sustained. The Maintenance Director will conduct house audit of all facility smoke compartments to ensure all penetrare identified and addressed. Maintenance Director will develop for all contractors who enter to work their work will include potential for ceiling work, and if the Above Ceiling Permitting requirement will need to implemented. The log will be reviet the QAPI committee at monthly me to identify any additional follow up. 4. Identify who is responsible for corrective actions and monitoring. | loset rials to I be put ses not litting of their Any y the tractor To ure a whole ations a log k, if above ng be ewed by | |

| _ ` ` | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION 03 - 2013 BUILDING | (X3) DATE SURVEY COMPLETED |
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| | | 245318 | B. WING | | 11/29/2022 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 201 KEENAN DRIVE NTERNATIONAL FALLS, MN 56649 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLÉTION |
| K 372 | Continued From pa | ge 7 | K 372 | responsible for presenting the whole house audit x 1 and the monthly contractor log to the QAPI committed monthly basis x 12 months. 5. Actual or proposed date for completion of remedy - January 17th 2023. | e on a |
| | signal and simulations. Fire drill unexpected times used to least quarterly on established routines between 9:00 PM announcement may alarms. 19.7.1.4 through 19.6. | e transmission of a fire alarm on of emergency fire is are held at expected and inder varying conditions, at ach shift. The staff is familiar is aware that drills are part of Where drills are conducted ind 6:00 AM, a coded in be used instead of audible 1.7.1.7 | K 712 | | 1/17/23 |
| | Based on a review and staff interview, fire drills under vari NFPA 101 (2012 ed sections 19.7.1.6, 4 deficient finding countries on the residents with Findings include: On 11/29/2022, betait was revealed by a documentation that | of available documentation the facility failed to conduct ed times and conditions per lition), Life Safety Code, .7.4, and 4.6.1.1. This ald have a widespread impact thin the facility. ween 10:30am and 11:30pm, a review of available the facility was unable to e drills in the first quarter | | K 712 □ Fire Drills 1. Detailed description of the correction taken or planned to correct the deficiency □ The facility has identified the record keeping of Fire Drill Comwill need to be maintained in a central location. Fire drill will be conducted the Evening Shift as scheduled on the Evening Shift as scheduled on the week of 1/3/23-1/6/23. The fire drill requirement and policy will be review the Maintenance Director or any designees that will conduct fire drills ongoing. 2. Address the measures that will | ed that pletion ral for he wed by |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l `´ | TIPLE CONSTRUCTION NG 03 - 2013 BUILDING | (X3) DATE SURVEY COMPLETED | |
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| | | 245318 | B. WING _ | | 11/29/2022 | |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 5.475 | |
| K 712 | third quarter (July - (October - December) An interview with the | second quarter (April - June), September) fourth quarter | K 7 | in place to ensure the deficiency does reoccur - The Maintenance Director create a Life Safety Code (LSC) bind with all documents required for reviet during a Life Safety Code inspection ensure all documents are prepared a time of inspection. Each tab will indit the frequency required for each task quick reference for any staff member ensure completion. 3. Indicate how the facility plans to monitor future performance to ensur solutions are sustained - The Maintenance Director will bring the L binder to the monthly QAPI Committed meetings for committee review and assurance of completion. 4. Identify who is responsible for corrective actions and monitoring compliance - The Maintenance Director will bring the LSC binder to the month QAPI Committee meetings for committee of completion. 5. Actual or proposed date for completion of remedy - January 17th 2023. | will der w to at the icate as a er to ce ctor thly nittee irance | |
| K 761 SS=F | | ection & Testing - Doors | K 76 | 61 | 1/17/23 | |
| | Fire doors assemble annually in accordance for Fire Doors and Non-rated doors, in patient rooms and seconds. | ection & Testing - Doors ies are inspected and tested ince with NFPA 80, Standard Other Opening Protectives. Icluding corridor doors to smoke barrier doors, are as part of the facility am. | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | IPLE CONSTRUCTION IG 03 - 2013 BUILDING | (X3) DATE SURV COMPLETE | |
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| | | 245318 | B. WING _ | | 11/ | 29/2022 |
| | PROVIDER OR SUPPLIE | R Y - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 5664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| K 761 | Individuals perfor testing possess key that demonstrates Written records of maintained and a 19.7.6, 8.3.3.1 (L.5.2, 5.2.3 (2010 N. This REQUIREM by: Based on a review doors per NFPA 1 Code section 8.3. edition), Standard Opening Protective finding could have residents within the Findings include: On 11/29/2022, by was revealed by a documentation the not completed. An interview with | ming the door inspections and nowledge, training or experience is ability. If inspection and testing are re available for review. In the facility failed to inspect fire for fire Doors and Other faces, section 5.2.1. This deficient is a widespread impact on the | K 76 | K 761 Maintenance Inspect Testing Doors 1. Detailed description of the action taken or planned to corr deficiency The facility is able documentation to support the of Fire Door Inspection most recompleted on 10/18/2022 by mostaff. 2. Address the measures that in place to ensure the deficiency reoccur - The Maintenance Director a Life Safety Code (LSC) with all documents required for during a Life Safety Code inspensure all documents are preptime of inspection. Each tab with frequency required for each quick reference for any staff mensure completion. 3. Indicate how the facility plamonitor future performance to solutions are sustained - The Maintenance Director will bring binder to the monthly QAPI Comeetings for committee review assurance of completion. 4. Identify who is responsible corrective actions and monitor compliance - The Maintenance | corrective ect the to produce completion ecently naintenance at will be put cy does not rector will c) binder review ection to pared at the vill indicate h task as a member to ans to ensure the LSC emmittee v and eforting | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G 03 - 2013 BUILDING | (X3) DATE COM | | |
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| | | 245318 | B. WING _ | | 11/2 | 29/2022 | |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE | |
| K 761 | Continued From pa | ge 10 | K 76 | responsible for development of the binder and for presenting the compared by the Door Inspection logs to the QA committee. 5. Actual or proposed date for completion of remedy - January 17 2023. | oleted API | | |
| K 901 SS=F | CFR(s): NFPA 101 Fundamentals - Bu Building systems at 1 through 4 require Categories are determined | • | K 90 | | | 1/17/23 | |
| | by: Based on a review and staff interview, provide a complete NFPA 99 (2012 edit Code, section 4.1. have a widespread the facility. Findings include: On 11/29/2022, 10: revealed during docinterview with the Market Staff Code and S | of available documentation the facility has failed to facility Risk Assessment pertion), Health Care Facilities This deficient finding could impact on the residents within 30am and 1:30pm, it was cumentation review and an faintenance Director that the ent document could not be e of the survey. | | K 901 □ Fundamentals □ 1. Detailed description of the corraction taken or planned to correct the deficiency □ The facility was able the produce a copy of the annual Facility Utilities Risk Assessment completed 12/17/21. The updated Facility Utilities Risk Assessment will be completed 1/17/23. 2. Address the measures that will in place to ensure the deficiency dereoccur - The Maintenance Director create a Life Safety Code (LSC) bility with all documents required for reviduring a Life Safety Code inspection. | the o ity ed on lities d before be put oes not or will nder iew | | |

| · · · · · · · · · · · · · · · · · · · | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION NG 03 - 2013 BUILDING | ` ' | (X3) DATE SURVEY COMPLETED | |
|---------------------------------------|--|--|---------------------|--|---|-------------------------------|--|
| | | 245318 | B. WING | | 11/ | 29/2022 | |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH APPROVIDENCY) | OULD BE | (X5) COMPLETION DATE | |
| K 901 | | ge 11 e Maintenance Director nt finding at the time of | K 9 | ensure all documents are prepatime of inspection. Each tab with the frequency required for each quick reference for any staff meensure completion. 3. Indicate how the facility plan monitor future performance to esolutions are sustained - The Maintenance Director will bring binder to the monthly QAPI Cormeetings for committee review assurance of completion. 4. Identify who is responsible corrective actions and monitoring compliance - The Maintenance responsible for development of binder and for presenting the Fautility Risk Assessment to the Committee. 5. Actual or proposed date for completion of remedy - January 2023. | Il indicate task as a ember to sure the LSC and for the LSC acilities API | | |