DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 24, 2020

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

RE: CCN: 245318
Cycle Start Date: November 6, 2020

Dear Administrator:

On November 25, 2020, we notified you a remedy was imposed. On December 17, 2020 the Minnesota Department of Health 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 December 14, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 10, 2020 be discontinued as of December 14, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of November 25, 2020, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 10, 2020. 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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Electronically delivered

December 24, 2020

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

Re: Reinspection Results
Event ID: 60KL12

Dear Administrator:

On December 17, 2020 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 24, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically Submitted
November 25, 2020

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

RE: CCN: 245318
Cycle Start Date: November 6, 2020

Dear Administrator:

On November 6, 2020, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On November 6, 2020, the situation of immediate jeopardy to potential health and safety cited at was removed. However, continued non-compliance remains at the lower scope and severity of F 880.

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 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 December 10, 2020.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a 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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 10, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 10, 2020, (42 CFR 488.417 (b)).

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.

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 $11,160; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 10, 2020. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.
- 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" tag), and emergency preparedness deficiencies (those preceded by 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, MN 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, Licensing and Certification Program 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 May 6, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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 DENIAL OF PAYMENT

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:

Tamika.Brown@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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	**2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 11/4/20, through 11/6/20 at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey and abbreviated survey was conducted on 11/4/20, through 11/6/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The following complaint was found to be SUBSTANTIATED: H5318028C with a deficiency issued at F880 The following complaint was found to be UNSUBSTANTIATED: H5318027C The survey resulted in an Immediate Jeopardy (IJ) to resident health and safety at F880. The IJ began on 10/20/20, when the facility removed R2's quarantine precautions 10 days after readmission to the facility following a hospitalization. R2 subsequently tested positive for COVID-19. R4's quarantine and transmission based precautions (TBP) were also removed 10	F 000		

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

Electronically Signed | 12/04/2020

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F 000	Continued From page 1 days following readmission to the facility. In addition, the facility failed to ensure TBP including gown use and eye protection were implemented according to the CDC guidelines for those on isolation and quarantine, in an effort to prevent cross contamination to other staff and subsequently residents. On 11/5/20, at 5:23 p.m. the administrator, director of nursing (DON) and infection preventionist (IP) were notified of the IJ. The IJ was removed on 11/6/20, at 3:51 p.m. when the facility implemented actions to reduce/ prevent the spread of COVID-19 within the facility. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		12/14/20

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F 880	Continued From page 2	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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F 880	Continued From page 3 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 follow Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19. The facility failed to ensure hospital returns were quarantined according to guidelines along with utilization of gowns in a manner to reduce the spread of infection for 2 or 2 residents (R2, R4) who were on isolation or quarantine. In addition, the facility failed to ensure staff wore the appropriate eye protection while in the patient care areas. These deficient practices resulted in an immediate jeopardy (IJ) situation for all 35 residents residing in the facility during the COVID-19 Focused Infection Control Survey. The IJ began on 10/20/20, when the facility removed R2's quarantine precautions 10 days after readmission to the facility following a hospitalization. R2 subsequently tested positive for COVID-19. R4's quarantine and transmission based precautions (TBP) were also removed 10 days following readmission to the facility. In	F 880	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. What was done immediately for the residents involved : On 11/6/2020-R4 was placed in TBP for droplet precautions to complete 14 days of isolation. Isolation unit was set up with appropriate PPE. Gowns, masks, and	

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F 880	Continued From page 4 addition, the facility failed to ensure TBP including gown use and eye protection were implemented according to the CDC guidelines for those on isolation and quarantine, in an effort to prevent cross contamination to other staff and subsequently residents. On 11/5/20, at 5:23 p.m. the administrator, director of nursing (DON) and infection preventionist (IP) were notified of the IJ. The IJ was removed on 11/6/20, at 3:51 p.m. when the facility implemented actions to reduce/ prevent the spread of COVID-19 within the facility. However, noncompliance remained at the lower scope and severity, widespread, which indicated no actual harm with potential for more than minimal harm that was not IJ (Level F). Findings include: The CDC guidance Coronavirus Disease 2019 (COVID-19) People at Increased Risk dated 9/11/20, identified the risk for severe illness from COVID-19 increased with age, with older adults at the highest risk. Severe illness means a person with COVID-19 may require hospitalization, intensive care, or a ventilator to help them breathe, or they may even die. On 11/4/20, at 12:00 p.m. upon entrance to the facility the DON stated the facility had one resident, R2, who was on isolation and TBP following a positive COVID-19 test on 10/27/20. R2 resided on the Voyageur wing which also housed residents negative for COVID-19. The Keptom wing was set up as the facility's COVID-19 wing but due to only one resident being positive the facility could not staff a separate wing for one resident. On 11/4/20, at 2:00 p.m. the administrator	F 880	face shields to be used one time per encounter and then discarded or reusable gowns to be laundered. Covid screening UDA is completed daily, and vital signs are complete at least once/and as needed per shift. Vital signs and status changes are reviewed daily by IDT. R2 on 11/6/2020 remained in isolation for droplet precautions to complete 14 days. Gowns, masks, and face shields to be used one time per encounter and then discarded or reusable gowns to be laundered. Covid screening UDA is completed daily, and vital signs are complete at least once/and as needed per shift. Vital signs and status changes are reviewed daily by IDT. 2. What was done to ensure that other resident that had the potential to be affected were reviewed to ensure they are not experiencing a deficient practice. On 10/27/20 when R2 had a positive BD Veritor rapid screening it was followed up with two PCR nasal pharyngeal tests. R2 was immediately placed in droplet TBP. All residents and staff were COVID tested. Daily UDA COVID screening continued as well as vital signs taken every shift. IDT continued to review all vital signs daily and followed up with any status changes. All equipment and surfaces were cleaned and disinfected in the units. 3. What process changes and re-training was provided, by who and when: On 11/6 and 11/7/2020 training was completed by Quality coordinator/IP and DNS with staff following CDC guidelines for TBP and use of PPE, donning/doffing	

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GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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F 880	Continued From page 5 indicated the facility did have a wing that was being allocated as the COVID-19 wing for positive COVID-19 residents. The administrator stated the facility had decided not to move their one positive COVID-19 resident to that wing because of staffing concerns. The administrator indicated they felt they had things controlled where the resident was and it would be a risk to move R2. QUARANTINE AND GOWN USE: The CDC Responding to Coronavirus (COVID) -19 in Nursing Homes updated 4/30/20, identified a facility should create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. All recommended personal protective equipment (PPE) should be worn during care of residents under observation and should include a facemask/respirator, eye protection, gloves and gown. Further, "Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic SARS-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be	F 880	of gowns, gloves, masks, and eye protection, and hand hygiene. All PPE including gowns in isolation unit to be used once per encounter. Education provided upon entrance to all staff on mandatory use of surgical face masks and eye protection all times while in resident spaces, that all admission/readmissions/Covid positive residents will remain in isolation for 14 days. All admissions/readmissions/Covid positive residents will be under TBP quarantine for 14 days. Facility will implement the facility cohorting plan placing all asymptomatic residents who are being admitted/readmitted to the nursing home from an outside facility and have no known exposure to Covid 19 into a gray (transitional zone). All asymptomatic residents who are not considered to be exposed to Covid 19 and remain in the Green Zone (COVID free na¿ve zone). All asymptomatic residents who may have been exposed to COVID-19, will remain in the yellow (quarantine zone). All residents who are symptomatic and suspected to have COVID-19 even if the test results are not back. Residents are kept in this zone for 14 days. If resident remains asymptomatic (no new symptoms, no fever) at the end of 14 days without the use of antipyretics, resident will then be move to the Green Zone. All residents that have tested positive for COVID-19 will remain in the red (isolation zone) for the longer of 10 days since onset of symptoms with no fever during the final 72 hours of that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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F 880	Continued From page 6 considered to increase certainty." The CDC Using Personal Protective Equipment (PPE) updated 8/19/20, identified gowns should be donned (put on) prior to entering the resident's room. The gown should be doffed (removed) while standing in the resident's room, if disposable it should be thrown away and if it was washable it should be bagged for laundry. R2's quarterly Minimum Data Set (MDS) dated 8/12/20, identified R2 had severe cognitive impairment and required assistance of one to two staff with activities of daily living (ADL's) including bed mobility, transfers, personal hygiene and locomotion on the unit. Diagnoses included dementia, history of TIA, muscle weakness along with heart and kidney disease. R2's progress note(s) from 10/10/20 through 10/27/20, identified the following: -10/9/20, R2 was sent to the area hospital where he was admitted to the hospital. -10/10/20, R2 was subsequently transferred to another hospital, out of the area, for further follow up. R2 was discharged back to the facility, following a procedure and a brief observational time. -10/20/20, R2 was taken off quarantine and droplet precautions, per the facility policy. [Removing precautions 4 days early was a potential for him to comingle with other residents and for staff to not protect themselves with gowns during cares.] -10/26/20, R2's family was notified R2 was	F 880	period (without antipyretics) and improvement of respiratory symptoms OR 14 days from the date of collection of the positive test result and no new onset of symptoms/fever. Facility will follow CDC guidelines for PPE. Reusable gowns will be used once per encounter and then laundered. Eye protection will be required in all resident spaces including over prescription lenses. To ensure compliance with infection control policies and procedures regarding isolation, facility cohorting procedure, infection prevention. Clinical Learning and Development Specialist will provide all staff training on 12/7, 12/8/2020, and 12/9/2020 on policy and procedures regarding infection prevention, isolation, review of cohorting plan, and proper PPE use in isolation areas. IP consultant has been contracted and will be onsite on 12/10/2020 and remain contracted for two months to assist in education with QAPI coordinator/IP and DNS and then with all staff. Infection control consultant responsibilities must include, but are not limited to, the following: " Work with the facility to conduct a Root Cause Analysis (RCA) to identify and address the reasons for noncompliance identified in the CMS-2567. " The facility□s Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee, must participate in the completion of the RCA. 4. Monitoring:	

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F 880	Continued From page 7 running a fever of 100.2 degrees Fahrenheit (F). -10/27/20, R2 had a temperature of 100.4 degrees (F) and family was notified R2 had tested positive for COVID-19. Further, R2 was placed back on isolation precautions. During observation on 11/4/20, at 1:35 p.m. R2's room had an infection control cart containing PPE and hand sanitizer outside the room along with a sign identifying R2 was on droplet precautions. R2's door was not closed as recommended by the CDC. During interview on 11/5/20, at 8:33 a.m. licensed practical nurse (LPN)-C stated R2 had a positive COVID-19 test on 10/27/20, and was placed on isolation precautions for 10 days. LPN-C stated they had been removing quarantine and TBP after 10 days for everyone who was under observation for potential exposure, following a hospital stay. -At 9:09 a.m. registered nurse (RN)-A stated R2 was transported to the hospital and returned on 10/10/20, R2 was placed in quarantine and TBP for 10 days from 10/10/20 through 10/20/20. On 10/23/20, R2 was again transported to an outside medical appointment and returned the same day. RN-A did not identify if R2 was wearing a mask when he left his rooom after precautions were lifted. R2 was again placed on quarantine and TBP following his appointment. R2 however, developed a fever on 10/26/20, and subsequently tested positive for COVID-19. R2 currently remained on isolation and TBP. During observation on 11/5/20, at 9:56 a.m.	F 880	Audits being completed by quality coordinator or designee daily x 7days followed by 3x/wkx4wks then wklyx12/wks. Observation audits will be completed on readmissions/admissions and COVID+ resident in isolation for 14 days, gowns being worn once, staff are wearing eye protection in general, staff wearing prescription glasses are wearing eye protection. Chart audits will be completed to assure isolation care plan is in place. Audit results will be reviewed and monitored by QAPI committee and recommendations will be put in place based on our findings. 5. Date Certain: 12/14/2020	

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	245318	A. BUILDING _____ B. WING _____	C 11/06/2020

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GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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F 880	Continued From page 8	F 880		

nursing assistant (NA)-E had on a facemask and walked to R2's room, donned a clean washable isolation gown, gloves and a face shield. NA-E entered R2's room and shut the door. NA-E as not observed to exit R2's room.

At 10:17 a.m. LPN-C donned gloves, reached into R2's room and took a used contaminated washable isolation gown off the back of R2's door. While standing in R2's doorway with gloved hands, LPN-C donned the previously used contaminated washable isolation gown, donned a face shield from the bin hanging on R2's door, entered the room and closed the door behind her.

During interview on 11/5/20, at 10:29 a.m. LPN-C stated there were hooks behind R2's door and on the wall. LPN-C stated she retrieved a clean washable isolation gown and after using the isolation gown, LPN-C hung the isolation gown on one of the hooks, instead of placing it in a hamper for washing. Further, LPN-C would continue to use the same [contaminated] isolation gown throughout the entire shift. The staff were instructed by the facility to reuse the washable isolation gowns for their entire shift. LPN-C did not know if the facility had any disposable gowns but had plenty of the washable isolation gowns.

At 3:37 p.m. NA-F stated the staff reuse the washable isolation gowns. Each staff obtained a clean washable isolation gown and after using it they were to hang it on a hook on the back of the door. They continued to use the same washable isolation gown the entire shift on the same person. NA-F was working part of two shifts so NA-F removed her gowns from the isolation rooms she had used on the day shift. When NA-F started the evening shift she would start with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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F 880	Continued From page 9	F 880		

clean washable isolation gowns again and then reuse them the rest of the evening shift. Further, the staff were instructed on reusing the washable isolation gowns by facility administration. The hooks were usually labeled but today there were two gowns hanging on unlabeled hooks behind R2's door.

During observation on 11/5/20, at 3:59 p.m. LPN-B exited R2's room with a contaminated washable isolation gown. LPN-B doffed the isolation gown and then reached into R2's room and hung the contaminated washable gown on an unlabelled hook in R2's room.

During interview on 11/5/20, at 4:02 p.m. LPN-B stated when entering R2's room she retrieved and donned the yellow isolation gown that she previously worn that day and hung on the hook in R2's room. Upon exiting R2's room she hung the same used gown on the same unlabelled hook. Further, LPN-B stated she would reuse the gown for the entire shift and then place in a red bag for laundering at the end of their shift. She was uncertain if other staff used her gown. Approximately a week and a half ago staff were instructed on how to don and doff PPE and how to hang the washable isolation gowns.

R4's quarterly MDS dated 9/1/20, identified R4 was cognitively intact and required extensive assistance of two staff for ADL's including bed mobility, transfers, dressing, toileting, and personal hygiene. Diagnoses included hemiplegia/paresis, seizure disorder/epilepsy, history of brain cancer.

R4's progress note(s) from 10/15/20 through 10/26/20, and identified the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	**2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649**

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F 880	Continued From page 10	F 880		

-10/15/20, R4 was transported and admitted to the local hospital for a medical condition.

-10/17/20, R4 was subsequently transferred to another hospital for further follow up.

-10/26/20, R4 returned to the facility, following further medical treatment and was placed on TBP on 10/26/20.

During observation on 11/4/20, at 1:35 p.m. R4 was sitting at the far end of her bedroom. At 3:11 p.m. RN-A donned a clean washable isolation gown from the isolation bin hanging on the outside of R4's door. RN-A obtained and donned a clean face shield that was hanging from infection control bin, then entered R4's room.

During observation on 11/5/20, at approximately 8:15 a.m. there was no longer an isolation cart outside of R4's room and no droplet precautions sign on door. A bedside table with a pump bottle of hand sanitizer was outside the room. R4's door was closed.

During interview on 11/5/20, at 8:18 a.m. LPN-A stated when first going into an isolation room for their shift she would don a washable isolation gown. She would put on gloves, either eye goggles for COVID-19 negative residents or a face shield if COVID-19 positive residents, and a face mask. When exiting the room would doff and throw away gloves and then doff and hang the used contaminated washable isolation gown on the hooks behind the residents door. The gown that was hung would be used for the remainder of the shift.

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F 880	Continued From page 11	F 880		

When interviewed on 11/5/20, at 11:30 a.m. the IP stated all hospital returns and new admissions were quarantined for 10 days, as long as they were asymptomatic. The IP found the quarantining information in the facility policy regarding quarantine zones. Residents that were symptomatic or tested positive were placed in the red zone; those that were exposed and under quarantine were placed in the yellow zone and hospital returns were placed in the gray zone, those in the gray zone only required 10 days of quarantine.

Further, the facility was using washable isolation gowns. Because they were "reusable" the staff were to hang the washable isolation gowns on hooks behind the resident's door. They were to use one gown per resident per shift. Upon exiting the room, staff would mark their hook and hang the washable isolation gown on the hook to reuse for each subsequent encounter on their shift. At the end of the shift staff were to remove the washable isolation gowns and double bag them for laundering. There was a potential staff would forget to mark their hook or contaminate themselves when reusing the isolation gowns. The decision to hang and reuse the washable isolation gowns for the shift was made by the nursing and administration staff. The facility had been previously using disposable gowns but are now using reusable gowns and updated their practice. Further, the IP did not know why they were not laundering the gowns after every use and identified the facility was not short on gown supplies. The IP stated she thought the facility was in conservation mode and did not want to run out of isolation gowns, if their was a large outbreak; however, the facility isolation gowns were reusable after they had been washed.

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GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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F 880	Continued From page 12 On 11/5/20, at 4:47 p.m. the facility administrator, DON and the IP were interviewed. The DON stated the staff would get a clean washable isolation gown for each resident upon entering a quarantine room, the first time of their shift. The staff would label the hook and place the used isolation gown on the hook. At the end of the shift the gown would be laundered. The IP stated the facility's practice changed about two weeks ago, and were previously sharing the used washable isolation gowns. The IP indicated there were three gowns hanging in the quarantine rooms and staff would share those gowns for that resident, through out their shift. The IP indicated the staff did not like sharing the gowns and so the facility had went to labeling the hooks at that point. The IP stated the staff were never instructed they should obtain a fresh gown with each resident encounter. The facility was not aware they could prioritize gown use for those on observation for COVID-19. The facility Cohorting Plan for SNFs [Skilled Nursing Facilities] updated 10/12/20, identified new admissions to the facility would be placed in the "gray" zone if they tested negative by a point of care analyzer or antigen card test. Further, staff should wear PPE including surgical masks, eye protection, gown and gloves as needed while taking care of the residents in the "gray zone." Residents should be kept in the "gray zone" for 14 days as long as they remained asymptomatic. The policy did not identify quarantine for observation status only could end at 10 days for any resident on observation status regardless of zone. The CDC Strategies for Optimizing the Supply of	F 880		

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F 880	Continued From page 13	F 880		

Isolation Gowns updated 10/9/20, identified the facility could prioritize gown use for those under observation. Gowns should be prioritized for the following activities: " During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures; During the following high-contact patient care activities that provide opportunities for transfer of pathogens to other patients and staff via the soiled clothing of healthcare providers, such as: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care."

EYE PROTECTION:

The CDC's guidance Interim Infection Prevention and Control Recommendations for Healthcare Personnel During Coronavirus Disease 2019 (COVID-19) Pandemic updated 11/4/20, identified healthcare personnel working in resident areas should wear eye protection in addition to a facemask.

On 11/4/20, at 3:01 p.m. NA-F was observed wearing eye goggles on the top of her head while assisting an unidentified resident with a snack and drink. NA-F was within 6 feet (ft) of the unidentified residents. NA-F stated she could not see when wearing eye protection and then placed the eye goggles correctly on her face.

On 11/4/20, at 5:07 p.m. NA-D was observed wearing prescription eye glasses and had eye goggles on the top of her head and not over their eyes in a resident care area. NA-D stated she could not see to chart if she was wearing the eye protection because they were tinted and hard to

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GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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F 880	Continued From page 14	F 880		

see out of.

During interview on 11/4/20, at 5:11 p.m. RN-A stated staff should wear eye goggles when in contact with residents for 15 minutes. If staff go into an isolation room they should wear the face shield and upon leaving the room they should disinfect it and don their own eye protection.

During observation on 11/4/20, at 5:17 p.m. NA-D was walking out of a resident's room wearing prescription eye glasses and eye goggles; however, the eye goggles were low on her face. The goggles were towards the end of her nose and below the level of prescription eye glasses, not covering the sides of their eyes.

During interview on 11/5/20, at 9:30 a.m. NA-G stated staff were supposed to wear eye goggles if they were in direct contact with residents for 15 minutes or more. NA-G was uncertain if prescription eye wear was okay. Some of the staff were told by administration that it was okay to only wear prescription glasses as long as they covered the eyes. Further, if staff wore prescription glasses they should not have to wear eye protection over them although staff probably should wear eye protection when they go into a positive COVID-19 resident room. NA-G was uncertain if there was a policy for that or not, and did not identify if they had received education regarding eye protection.

When interviewed on 11/5/20, at 11:42 a.m. the IP stated she had told all staff to wear goggles in resident care areas and when entering an isolation room they had wear a faceshield. it was an infection concern if prescription glasses are not being cleaned properly between residents

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 15	F 880		

rooms, eye protection prevents the spread of COVID-19 and she recommends all staff wear eye protection at all times when on the units and to wear a face shield when in an isolation room.

The facility policy Emerging Threats- Acute Respiratory Syndromes Coronavirus (COVID) - Enterprise revised 4/30/20, identified eye protection that covered both the front and sides of the face should be used in resident areas.

The IJ that began on 11/5/20, was removed on 11/6/20, at 3:51 p.m. when it could be verified through observation, interview and document review the facility had reviewed and revised facility procedures and practices to reduce/ prevent the spread of COVID-19 within the facility. These interventions included placing R4 back on quarantine; implementing and educating staff on 14 day admission/ readmission quarantine practices regardless of COVID-19 status, completed risk assessments to determine which residents were high risk exposes due to the deficient practice; revising gown procedures and educated staff on using one gown per resident interaction, along with following the CDC guidance for optimizing gown use for residents on observation/quarantine status; reinforced education with staff to ensure appropriate eye protection was worn in all resident care areas; along with implementing a system to monitor staff for adherence to the expected procedures and practices.

Electronically delivered
November 25, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: 60KL11

Dear Administrator:

The above facility was surveyed on November 4, 2020 through November 6, 2020 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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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, MN 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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On date 11/4/20 through 11/6/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5318028C with a licensing order issued at MN Rule 4658.0800 Subp. 1 The following complaint was found to be UNSUBSTANTIATED: H5318027C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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2 000	Continued From page 2 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. 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.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19. The facility failed to ensure hospital returns were quarantined according to guidelines along with utilization of gowns in a manner to reduce the spread of infection for 2 or 2 residents (R2, R4) who were on isolation or quarantine. In addition, the facility failed to ensure staff wore the appropriate eye protection while in the patient care areas. These deficient practices resulted in	21375	Completed	12/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 11/06/2020

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GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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21375	Continued From page 3	21375		

an immediate jeopardy (IJ) situation for all 35 residents residing in the facility during the COVID-19 Focused Infection Control Survey.

The IJ began on 10/20/20, when the facility removed R2's quarantine precautions 10 days after readmission to the facility following a hospitalization. R2 subsequently tested positive for COVID-19. R4's quarantine and transmission based precautions (TBP) were also removed 10 days following readmission to the facility. In addition, the facility failed to ensure TBP including gown use and eye protection were implemented according to the CDC guidelines for those on isolation and quarantine, in an effort to prevent cross contamination to other staff and subsequently residents. On 11/5/20, at 5:23 p.m. the administrator, director of nursing (DON) and infection preventionist (IP) were notified of the IJ. The IJ was removed on 11/6/20, at 3:51 p.m. when the facility implemented actions to reduce/ prevent the spread of COVID-19 within the facility. However, noncompliance remained at the lower scope and severity, widespread, which indicated no actual harm with potential for more than minimal harm that was not IJ (Level F).

Findings include:

The CDC guidance Coronavirus Disease 2019 (COVID-19) People at Increased Risk dated 9/11/20, identified the risk for severe illness from COVID-19 increased with age, with older adults at the highest risk. Severe illness means a person with COVID-19 may require hospitalization, intensive care, or a ventilator to help them breathe, or they may even die.

On 11/4/20, at 12:00 p.m. upon entrance to the facility the DON stated the facility had one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 11/06/2020

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GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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21375	Continued From page 4	21375		

resident, R2, who was on isolation and TBP following a positive COVID-19 test on 10/27/20. R2 resided on the Voyageur wing which also housed residents negative for COVID-19. The Keptom wing was set up as the facility's COVID-19 wing but due to only one resident being positive the facility could not staff a separate wing for one resident.

On 11/4/20, at 2:00 p.m. the administrator indicated the facility did have a wing that was being allocated as the COVID-19 wing for positive COVID-19 residents. The administrator stated the facility had decided not to move their one positive COVID-19 resident to that wing because of staffing concerns. The administrator indicated they felt they had things controlled where the resident was and it would be a risk to move R2.

QUARANTINE AND GOWN USE:

The CDC Responding to Coronavirus (COVID) -19 in Nursing Homes updated 4/30/20, identified a facility should create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. All recommended personal protective equipment (PPE) should be worn during care of residents under observation and should include a facemask/respirator, eye protection, gloves and gown. Further, "Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic SARS-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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21375	Continued From page 5	21375		

admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty."

The CDC Using Personal Protective Equipment (PPE) updated 8/19/20, identified gowns should be donned (put on) prior to entering the resident's room. The gown should be doffed (removed) while standing in the resident's room, if disposable it should be thrown away and if it was washable it should be bagged for laundry.

R2's quarterly Minimum Data Set (MDS) dated 8/12/20, identified R2 had severe cognitive impairment and required assistance of one to two staff with activities of daily living (ADL's) including bed mobility, transfers, personal hygiene and locomotion on the unit. Diagnoses included dementia, history of TIA, muscle weakness along with heart and kidney disease.

R2's progress note(s) from 10/10/20 through 10/27/20, identified the following:

-10/9/20, R2 was sent to the area hospital where he was admitted to the hospital.

-10/10/20, R2 was subsequently transferred to another hospital, out of the area, for further follow up. R2 was discharged back to the facility, following a procedure and a brief observational time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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21375	Continued From page 6	21375		

-10/20/20, R2 was taken off quarantine and droplet precautions, per the facility policy. [Removing precautions 4 days early was a potential for him to comingle with other residents and for staff to not protect themselves with gowns during cares.]

-10/26/20, R2's family was notified R2 was running a fever of 100.2 degrees Fahrenheit (F).

-10/27/20, R2 had a temperature of 100.4 degrees (F) and family was notified R2 had tested positive for COVID-19. Further, R2 was placed back on isolation precautions.

During observation on 11/4/20, at 1:35 p.m. R2's room had an infection control cart containing PPE and hand sanitizer outside the room along with a sign identifying R2 was on droplet precautions. R2's door was not closed as recommended by the CDC.

During interview on 11/5/20, at 8:33 a.m. licensed practical nurse (LPN)-C stated R2 had a positive COVID-19 test on 10/27/20, and was placed on isolation precautions for 10 days. LPN-C stated they had been removing quarantine and TBP after 10 days for everyone who was under observation for potential exposure, following a hospital stay.

-At 9:09 a.m. registered nurse (RN)-A stated R2 was transported to the hospital and returned on 10/10/20, R2 was placed in quarantine and TBP for 10 days from 10/10/20 through 10/20/20. On 10/23/20, R2 was again transported to an outside medical appointment and returned the same day. RN-A did not identify if R2 was wearing a mask when he left his rooom after precautions were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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21375	Continued From page 7	21375		

lifted. R2 was again placed on quarantine and TBP following his appointment. R2 however, developed a fever on 10/26/20, and subsequently tested positive for COVID-19. R2 currently remained on isolation and TBP.

During observation on 11/5/20, at 9:56 a.m. nursing assistant (NA)-E had on a facemask and walked to R2's room, donned a clean washable isolation gown, gloves and a face shield. NA-E entered R2's room and shut the door. NA-E as not observed to exit R2's room.

At 10:17 a.m. LPN-C donned gloves, reached into R2's room and took a used contaminated washable isolation gown off the back of R2's door. While standing in R2's doorway with gloved hands, LPN-C donned the previously used contaminated washable isolation gown, donned a face shield from the bin hanging on R2's door, entered the room and closed the door behind her.

During interview on 11/5/20, at 10:29 a.m. LPN-C stated there were hooks behind R2's door and on the wall. LPN-C stated she retrieved a clean washable isolation gown and after using the isolation gown, LPN-C hung the isolation gown on one of the hooks, instead of placing it in a hamper for washing. Further, LPN-C would continue to use the same [contaminated] isolation gown throughout the entire shift. The staff were instructed by the facility to reuse the washable isolation gowns for their entire shift. LPN-C did not know if the facility had any disposable gowns but had plenty of the washable isolation gowns.

At 3:37 p.m. NA-F stated the staff reuse the washable isolation gowns. Each staff obtained a clean washable isolation gown and after using it they were to hang it on a hook on the back of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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21375	Continued From page 8	21375		

door. They continued to use the same washable isolation gown the entire shift on the same person. NA-F was working part of two shifts so NA-F removed her gowns from the isolation rooms she had used on the day shift. When NA-F started the evening shift she would start with clean washable isolation gowns again and then reuse them the rest of the evening shift. Further, the staff were instructed on reusing the washable isolation gowns by facility administration. The hooks were usually labeled but today there were two gowns hanging on unlabeled hooks behind R2's door.

During observation on 11/5/20, at 3:59 p.m. LPN-B exited R2's room with a contaminated washable isolation gown. LPN-B doffed the isolation gown and then reached into R2's room and hung the contaminated washable gown on an unlabelled hook in R2's room.

During interview on 11/5/20, at 4:02 p.m. LPN-B stated when entering R2's room she retrieved and donned the yellow isolation gown that she previously worn that day and hung on the hook in R2's room. Upon exiting R2's room she hung the same used gown on the same unlabelled hook. Further, LPN-B stated she would reuse the gown for the entire shift and then place in a red bag for laundering at the end of their shift. She was uncertain if other staff used her gown. Approximately a week and a half ago staff were instructed on how to don and doff PPE and how to hang the washable isolation gowns.

R4's quarterly MDS dated 9/1/20, identified R4 was cognitively intact and required extensive assistance of two staff for ADL's including bed mobility, transfers, dressing, toileting, and personal hygiene. Diagnoses included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 9	21375		

hemiplegia/paresis, seizure disorder/epilepsy, history of brain cancer.

R4's progress note(s) from 10/15/20 through 10/26/20, and identified the following:

-10/15/20, R4 was transported and admitted to the local hospital for a medical condition.

-10/17/20, R4 was subsequently transferred to another hospital for further follow up.

-10/26/20, R4 returned to the facility, following further medical treatment and was placed on TBP on 10/26/20.

During observation on 11/4/20, at 1:35 p.m. R4 was sitting at the far end of her bedroom. At 3:11 p.m. RN-A donned a clean washable isolation gown from the isolation bin hanging on the outside of R4's door. RN-A obtained and donned a clean face shield that was hanging from infection control bin, then entered R4's room.

During observation on 11/5/20, at approximately 8:15 a.m. there was no longer an isolation cart outside of R4's room and no droplet precautions sign on door. A bedside table with a pump bottle of hand sanitizer was outside the room. R4's door was closed.

During interview on 11/5/20, at 8:18 a.m. LPN-A stated when first going into an isolation room for their shift she would don a washable isolation gown. She would put on gloves, either eye goggles for COVID-19 negative residents or a face shield if COVID-19 positive residents, and a face mask. When exiting the room would doff and throw away gloves and then doff and hang the used contaminated washable isolation gown

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 10	21375		

on the hooks behind the residents door. The gown that was hung would be used for the remainder of the shift.

When interviewed on 11/5/20, at 11:30 a.m. the IP stated all hospital returns and new admissions were quarantined for 10 days, as long as they were asymptomatic. The IP found the quarantining information in the facility policy regarding quarantine zones. Residents that were symptomatic or tested positive were placed in the red zone; those that were exposed and under quarantine were placed in the yellow zone and hospital returns were placed in the gray zone, those in the gray zone only required 10 days of quarantine.

Further, the facility was using washable isolation gowns. Because they were "reusable" the staff were to hang the washable isolation gowns on hooks behind the resident's door. They were to use one gown per resident per shift. Upon exiting the room, staff would mark their hook and hang the washable isolation gown on the hook to reuse for each subsequent encounter on their shift. At the end of the shift staff were to remove the washable isolation gowns and double bag them for laundering. There was a potential staff would forget to mark their hook or contaminate themselves when reusing the isolation gowns. The decision to hang and reuse the washable isolation gowns for the shift was made by the nursing and administration staff. The facility had been previously using disposable gowns but are now using reusable gowns and updated their practice. Further, the IP did not know why they were not laundering the gowns after every use and identified the facility was not short on gown supplies. The IP stated she thought the facility was in conservation mode and did not want to run

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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21375	Continued From page 11	21375		

out of isolation gowns, if their was a large outbreak; however, the facility isolation gowns were reusable after they had been washed.

On 11/5/20, at 4:47 p.m. the facility administrator, DON and the IP were interviewed. The DON stated the staff would get a clean washable isolation gown for each resident upon entering a quarantine room, the first time of their shift. The staff would label the hook and place the used isolation gown on the hook. At the end of the shift the gown would be laundered. The IP stated the facility's practice changed about two weeks ago, and were previously sharing the used washable isolation gowns. The IP indicated there were three gowns hanging in the quarantine rooms and staff would share those gowns for that resident, through out their shift. The IP indicated the staff did not like sharing the gowns and so the facility had went to labeling the hooks at that point. The IP stated the staff were never instructed they should obtain a fresh gown with each resident encounter. The facility was not aware they could prioritize gown use for those on observation for COVID-19.

The facility Cohorting Plan for SNFs [Skilled Nursing Facilities] updated 10/12/20, identified new admissions to the facility would be placed in the "gray" zone if they tested negative by a point of care analyzer or antigen card test. Further, staff should wear PPE including surgical masks, eye protection, gown and gloves as needed while taking care of the residents in the "gray zone." Residents should be kept in the "gray zone" for 14 days as long as they remained asymptomatic. The policy did not identify quarantine for observation status only could end at 10 days for any resident on observation status regardless of zone.

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	00322	A. BUILDING: _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 12	21375		

The CDC Strategies for Optimizing the Supply of Isolation Gowns updated 10/9/20, identified the facility could prioritize gown use for those under observation. Gowns should be prioritized for the following activities: " During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures; During the following high-contact patient care activities that provide opportunities for transfer of pathogens to other patients and staff via the soiled clothing of healthcare providers, such as: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care."

EYE PROTECTION:

The CDC's guidance Interim Infection Prevention and Control Recommendations for Healthcare Personnel During Coronavirus Disease 2019 (COVID-19) Pandemic updated 11/4/20, identified healthcare personnel working in resident areas should wear eye protection in addition to a facemask.

On 11/4/20, at 3:01 p.m. NA-F was observed wearing eye goggles on the top of her head while assisting an unidentified resident with a snack and drink. NA-F was within 6 feet (ft) of the unidentified residents. NA-F stated she could not see when wearing eye protection and then placed the eye goggles correctly on her face.

On 11/4/20, at 5:07 p.m. NA-D was observed wearing prescription eye glasses and had eye goggles on the top of her head and not over their eyes in a resident care area. NA-D stated she could not see to chart if she was wearing the eye

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21375	Continued From page 13	21375		

protection because they were tinted and hard to see out of.

During interview on 11/4/20, at 5:11 p.m. RN-A stated staff should wear eye goggles when in contact with residents for 15 minutes. If staff go into an isolation room they should wear the face shield and upon leaving the room they should disinfect it and don their own eye protection.

During observation on 11/4/20, at 5:17 p.m. NA-D was walking out of a resident's room wearing prescription eye glasses and eye goggles; however, the eye goggles were low on her face. The goggles were towards the end of her nose and below the level of prescription eye glasses, not covering the sides of their eyes.

During interview on 11/5/20, at 9:30 a.m. NA-G stated staff were supposed to wear eye goggles if they were in direct contact with residents for 15 minutes or more. NA-G was uncertain if prescription eye wear was okay. Some of the staff were told by administration that it was okay to only wear prescription glasses as long as they covered the eyes. Further, if staff wore prescription glasses they should not have to wear eye protection over them although staff probably should wear eye protection when they go into a positive COVID-19 resident room. NA-G was uncertain if there was a policy for that or not, and did not identify if they had received education regarding eye protection.

When interviewed on 11/5/20, at 11:42 a.m. the IP stated she had told all staff to wear goggles in resident care areas and when entering an isolation room they had wear a faceshield. it was an infection concern if prescription glasses are not being cleaned properly between residents

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21375	Continued From page 14	21375		

rooms, eye protection prevents the spread of COVID-19 and she recommends all staff wear eye protection at all times when on the units and to wear a face shield when in an isolation room.

The facility policy Emerging Threats- Acute Respiratory Syndromes Coronavirus (COVID) - Enterprise revised 4/30/20, identified eye protection that covered both the front and sides of the face should be used in resident areas.

The IJ that began on 11/5/20, was removed on 11/6/20, at 3:51 p.m. when it could be verified through observation, interview and document review the facility had reviewed and revised facility procedures and practices to reduce/ prevent the spread of COVID-19 within the facility. These interventions included placing R4 back on quarantine; implementing and educating staff on 14 day admission/ readmission quarantine practices regardless of COVID-19 status, completed risk assessments to determine which residents were high risk exposes due to the deficient practice; revising gown procedures and educated staff on using one gown per resident interaction, along with following the CDC guidance for optimizing gown use for residents on observation/quarantine status; reinforced education with staff to ensure appropriate eye protection was worn in all resident care areas; along with implementing a system to monitor staff for adherence to the expected procedures and practices.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could develop/revise or review policies and procedures for COVID-19. This should include quarantine, gown use, eye protection. The DON or designee could provide education to all staff . The DON or

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21375	Continued From page 15 designee could develop a system to monitor the CDC/MDH website for changes in the guidence. The DON or designee could identify a system for monitoring to ensure ongoing compliance and report the findings to the QAPI. SEE ALSO THE DPoC LETTER. Time Period for Correction: Twenty-one days	21375		