DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 28, 2023

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

Re: Reinspection Results
Event ID: Q6ZN12

Dear Administrator:

On July 25, 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 May 25, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 8, 2023

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

RE: CCN: 245318
Cycle Start Date: May 25, 2023

Dear Administrator:

On May 25, 2023, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 25, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 25, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 05/25/2023

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
F 000	INITIAL COMMENTS On 5/24/23-5/25/23,, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiency. H53182359C (MN91763) The following complaints were reviewed. H53182255C (MN93576) with a deficiency issued at F684 H53182406C (MN91106) with a deficiency issued at F689 H53182358C (MN92903) with a deficiency issued at F689 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		7/17/23

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

Electronically Signed | 06/16/2023

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.

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F 684	Continued From page 1 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to conduct a post fall assessment for 1 of 3 residents (R1) reviewed for Findings include: R1's significant change Minimum Data Set dated 5/3/23, identified intact cognition. R1's care plan dated 5/18/23, identified a self care deficit and a risk for falls related to Parkinson's disease, weakness and pain. The care plan identified a fall with fracture. Facility Progress notes dated 5/11/23, written by trained medication aide (TMA)-A, indicated at 6:15 p.m. R1 bent over to pick up something off the floor while staff was present and fell to the floor. The note indicated R1 stated her butt was a little sore but she did not hurt anything. Staff will continue to monitor. At 6:25 p.m. R1 was walking from her bed to her chair to grab her call light which caused her to lose her balance and she ended up on the floor. R1 stated she was fine, staff will continue to monitor. At 8:30 p.m. R1 put on her call light and said she had called her family member because her thigh on her left leg hurt and she could not move it. Staff (TMA) checked over R1's body for marks or bruises but did not find anything. R1 stated her pain was 9/10 and she could not put any weight on her leg. R1 said she wanted to go to the hospital. Staff called nurse to inform her of R1's decision. Progress	F 684	F684 Quality of Care: 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R1 was identified as not having a post fall assessment completed in a timely manner. On 5/24/23, DNS provided education to the licensed nurses involved in incident (5/11/23) which included definition of a fall, expectations of licensed nurses during a fall and the proper procedure. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All resident at risk for falls have the potential to be affect. DNS and RN designee will review falls during morning clinical and ensure timeliness and completeness of incident report as well as post fall assessment. On-call RN will review the falls daily on the weekend. During non-business hours the RN on-call will be notified of a fall immediately and will verify that a licensed nurse completed the following: i. Vitals-blood pressure, pulse, respiratory rate, pulse oximetry and temperature (if able). Check blood glucose if resident is symptomatic of blood glucose issues. ii. Perform a full-body exam with ROM	

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F 684	Continued From page 2 Note dated 5/12/23, indicated R1 had sustained a femur fracture. During interview on 5/24/23, at 10:50 a.m. R1 was lying in bed awake and said waiting for the nurse to bring her pain medications. R1 stated the night she fell (5/11/23) she was not sure what happened and said she fell, hit her head on the tray table and hit her arm. R1 said staff picked her up and put her in bed. R1 said she called her daughter because she knew something was wrong and it hurt "so bad." On 5/24/23, at 3:54 p.m. licensed practical nurse (LPN)-A stated she was working the first time R1 had fallen on 5/11/23. LPN-A said she did not know the exact time but said it was some time after six and said the nursing assistants (NA)'s saw her fall. LPN-A stated as she was walking out the door at the end of her shift she heard the TMA say R1 was on the ground again. LPN-A said she was leaving so they were taking care of it. LPN-A stated she did not know what happened. LPN-A stated after a fall staff should assess skin, ask if they hurt and if they hit their head do neurological checks. LPN-A stated she had not done an assessment either time R1 fell and said it was not required unless she hit her head. LPN-A stated after she left whichever nurse was on duty would have been responsible. On 5/24/23, at 4:02 p.m. registered nurse (RN)-A stated on 5/11/23, she received a phone call from the TMA on the unit who reported R1 had two falls in the last few minutes. RN-A stated she was unsure if the falls were witnessed. The DON who was present during the interview stated after a fall, staff should assess the resident for range of motion, bruises, pain, etcetera before assisting	F 684	to determine if there may be an injury and direct whether to move the resident. Do not attempt to move resident if suspected head, spinal or hip injury. iii. If the fall was not witnessed, neurological checks are required and must be documented in the medical record. iv. Continue to monitor the resident's condition; communicate updates as needed. v. Notified the physician and resident representative of the incident. DNS and/or RN designee will review fall assessments (high risk) from the last 60 days to ensure person centered fall interventions are care planned and appropriate for resident. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Clinical staff will attend a fall in-service to go over facility fall policy and procedures, clinical expectations during and after a fall, how to perform a thorough full-body exam and assessment. All residents who have a fall will be followed in weekly high risk meeting for 4 weeks to ensure interventions remain appropriate or need modification or revision. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DNS, Quality Specialist and/or designee will conduct audits of the data sources listed in above #2. Daily x 2weeks, 3x/wk for 2 weeks, 1x/wk for 4 weeks then 1x month x 3 months until	

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

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F 684	Continued From page 3 the resident up off the floor. The DON stated an assessment should always be completed and said she thought staff may have been confused because the falls were witnessed. The DON stated the nurse in the building should have completed an assessment. Facility policy Fall Prevention and Management dated 3/29/23, indicated: following a fall, do not move the resident. Stay with the resident and summon the licensed nurse for help. The policy indicated A nurse must observe the resident and perform a full-body exam to determine if there may be suspected injury and direct whether to move the resident.	F 684	compliance is sustained. The results will be brought to the monthly QAPI meeting for review and/or further recommendations. 5. The date that each deficiency will be corrected. July 17th, 2023	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care for falls for 1 of 3 residents (R4) assessed to be at risk for falls. Findings include: R4's admission Minimum Data Set (MDS) identified intact cognition and indicated he	F 689	F689 Free of Accident and Hazards/Supervision/Devices: 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R4 was identified at risk for falls with care plan stating, “Not to be left in wheelchair alone in resident room.” Resident was observed in his wheelchair	7/17/23

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F 689	Continued From page 4 required extensive assistance with staff for bed mobility, transfers and toileting. R4's MDS indicated he sustained a fall with fracture in the past six months prior to admission. R4's care plan dated 5/18/23, identified a self care deficit and a risk for falls. The care plan indicated R1 was not to be left in his wheel chair in his room alone. R4's Progress Note dated 5/12/23, indicated high risk committee reviewed fall from 5/5/23. R4 was found on the floor between his bed and his rocking chair and was unable to explain what he had been doing. R4 had an extensive history of self transfers and ambulating without assistance. R4 was not to be left alone in his wheel chair in his room. During observation on 5/25/23, at 9:03 a.m. R4 was seated in a chair in his room. At 9:08 R4 pressed his call light. DNA-A entered the room. At 9:36 a.m. R4 was again observed in his room and was seated in his wheel chair. At 9:40 a.m. R4 was observed wheeling himself into his bathroom. At 9:43 a.m. R4 was standing up from the toilet independent at which time survey notified staff of the self transfer. During interview on 5/25/23, at 9:52 a.m. NA-A stated she was present twice when R4 had fallen but the falls had not been witnessed. NA-A stated both times R4 had attempted to self transfer and had not used his call light. NA-A stated fall interventions were on the KARDEX (nursing assistant care guide). On 5/25/23, at 9:53 a.m. RN-B stated R4's interventions included monitoring every 30	F 689	in his room without supervision. R4 care plan was reviewed and modified with appropriate and current interventions in place, staff educated on updates. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. DNS and/or RN designee will review current residents care plans who scored medium to high risk for falls on their falls assessment for accurate, person-centered interventions and ensure care plans are up to date. During morning clinical meeting DNS/Designee will go over safety concerns both resident and facility, falls and changes in ADL performance. Any changes discussed will be updated to care plan immediately, and the RN of the resident household will do a huddle to update clinical staff of changes following morning meeting. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Clinical in-service will be held to educate staff on facility policy and procedures; Fall Prevention and Management, Person-Center Care, Comprehensive Care Plan and reviewing of Kardex. Education will also address implementation of shift report guide; and giving shift report together (RN/LPN and CNA) in hopes of better communication about the residents to the floor staff. DNS/Designee will implement a fall management program that includes certified nursing assistants, dietary, licensed nurses and therapy. This program will determine residents at high	

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

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F 689	Continued From page 5 minutes, anti-rollbacks on his wheel chair and said he had a flat call light placed next to him in bed to monitor his movements. RN-B stated R4's care plan also indicated he should not been left in his wheel chair alone in his room and stated staff should have been aware. A facility policy related to following the plan of care was requested but not received.	F 689	risk for falls, discuss at-risk residents and formulate changes to care plans and assist with root cause analysis. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DNS, Quality Specialist and/or designee will conduct observation audits of the data sources listed in above #2 .Daily 1X/wk, 3x/wk for 2 weeks, 1x/wk for 4 weeks then 1x month x 3 months until compliance is sustained. The results will be brought to the monthly QAPI meeting for review and/or further recommendations. 4. The date that each deficiency will be corrected. July 17th 2023	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 8, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: Q6ZN11

Dear Administrator:

The above facility was surveyed on May 24, 2023 through May 25, 2023 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	05/25/2023

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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 5/24/23-5/25/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	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 _____	05/25/2023

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 identify the date when they will be completed. The following complaint was reviewed with no orders issued.. H53182359C (MN91763) H53182255C (MN93576) The following complaints were reviewed. H53182406C (MN91106) with a licensing order issued at 0830 H53182358C (MN92903) with a licensing order issued at 0830 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 surveyor's 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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 enter the word "CORRECTED" in the box available for text. You must then indicate in the	2 000		

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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care for falls for 1 of 3 residents (R4) assessed to be at risk for falls.	2 830	The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to ensure interventions are being implemented. They	7/17/23

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2 830	Continued From page 3 Findings include: R4's admission Minimum Data Set (MDS) identified intact cognition and indicated he required extensive assistance with staff for bed mobility, transfers and toileting. R4's MDS indicated he sustained a fall with fracture in the past six months prior to admission. R4's care plan dated 5/18/23, identified a self care deficit and a risk for falls. The care plan indicated R1 was not to be left in his wheel chair in his room alone. R4's Progress Note dated 5/12/23, indicated high risk committee reviewed fall from 5/5/23. R4 was found on the floor between his bed and his rocking chair and was unable to explain what he had been doing. R4 had an extensive history of self transfers and ambulating without assistance. R4 was not to be left alone in his wheel chair in his room. During observation on 5/25/23, at 9:03 a.m. R4 was seated in a chair in his room. At 9:08 R4 pressed his call light. DNA-A entered the room. At 9:36 a.m. R4 was again observed in his room and was seated in his wheel chair. At 9:40 a.m. R4 was observed wheeling himself into his bathroom. At 9:43 a.m. R4 was standing up from the toilet independent at which time survey notified staff of the self transfer. During interview on 5/25/23, at 9:52 a.m. NA-A stated she was present twice when R4 had fallen but the falls had not been witnessed. NA-A stated both times R4 had attempted to self transfer and had not used his call light. NA-A stated fall interventions were on the KARDEX (nursing assistant care guide).	2 830	could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.	

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2 830	Continued From page 4 On 5/25/23, at 9:53 a.m. RN-B stated R4's interventions included monitoring every 30 minutes, anti-rollbacks on his wheel chair and said he had a flat call light placed next to him in bed to monitor his movements. RN-B stated R4's care plan also indicated he should not been left in his wheel chair alone in his room and stated staff should have been aware. A facility policy related to following the plan of care was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to ensure interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		