DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2022

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

RE: CCN: 245318
Cycle Start Date: June 29, 2022

Dear Administrator:

On July 11, 2022, we notified you a remedy was imposed. On August 2, 2022 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 July 19, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 26, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 11, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 30, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 19, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 15, 2022

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

Re: Reinspection Results
Event ID: HMJ412

Dear Administrator:

On August 2, 2022 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 August 2, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
July 11, 2022

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

RE: CCN: 245318
Cycle Start Date: June 29, 2022

Dear Administrator:

On June 29, 2022, 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 **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On June 29, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 July 26, 2022.

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 July 26, 2022 (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 July 26, 2022, (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 $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 29, 2022. 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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - International Falls is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 29, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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" and/ or "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 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 December 29, 2022 (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, Compliance Analyst
Minnesota Department of Health
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 06/29/2022

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 6/27/22 - 6/29/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H53182887C (MN84493), with a deficiency cited at F689. The immediate jeopardy began on 6/20/22, when an unlicensed/non-certified (HM-A) staff assisted R1 to the bathroom while not utilizing care planned interventions resulting in a fall with fracture. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 4:00 pm. on 6/28/22. The IJ began on 6/28/22, and the immediacy was removed on 6/29/22. The above findings constituted substandard quality of care, and an extended survey was conducted on 6/29/22. As a result of the investigation, a related deficiency will also be cited at F609. 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	F 000		

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

Electronically Signed | 07/15/2022

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

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 06/29/2022

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	Continued From page 1 validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report a serious bodily injury within two hours to the state agency (SA) for 1 of 1	F 609	Deficiency tag…F609…… ……	7/19/22

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 06/29/2022

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 609	Continued From page 2 residents (R1) who had a fall with fracture resulting from staff not following the plan of care. Findings include: A report to the SA dated 6/21/22, indicated on 6/20/22, R1 had gone down to the live music program off the unit in the fellowship hall. R1 had to use the bathroom so a homemaker (HM) brought him to the public restroom. The HM let R1 in the bathroom and closed the door. A minute later she heard him fall and start yelling for help. The HM went in the bathroom and found R1 on the floor. R1 complained of pain rated 10/10 in his shoulder so an ambulance was called. Resident left the building at approximately 3:15 p.m. R1 was seen in the emergency room and diagnosed with a right proximal shoulder fracture. R1's care plan and fall prevention measures were reviewed by the interdisciplinary team (IDT). The resident was identified as needing assist of one staff with gait belt for transfers which would include going to the bathroom. The resident had been assisted by a staff, but it was a HM who was not certified nursing assistant. It was unlikely that a gait belt was used as a HM would not likely bring one along to an activity. On 6/27/22, at 4:29 p.m. the administrator stated she had spoken to the HM involved in the incident who acknowledged she had not been using a transfer belt. During interview on 6/29/22, at 2:35 p.m. the administrator stated when the incident occurred she was aware R1 had complained of arm pain and went to the hospital. The administrator stated she was not aware until the next day R1 had sustained a fracture and at that time his care plan	F 609	1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility has identified the resident effected by deficient practice and responded with an OHFC report of serious bodily injury on 6/21/2022. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The facility has identified that all residents have the potential to be effected by the deficient practice if a reportable incident were to occur. The leadership staff who are responsible for completing reports to the SA were provided education on the facility policies for timely reporting to include instances in which serious bodily injury is suspected or confirmed, and care plan has not been followed. 3) What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. A checklist has been developed using MN State Statute and Good Samaritan Society policy and procedures which will be used each time an incident occurs which provides prompts to staff and leadership for incident reporting scenarios and timeframes. The checklist will be incorporated into the incident reporting process. This checklist will inform staff and leadership when an incident should be reported in 2 hours vs 24 hours and	

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 06/29/2022

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 609	Continued From page 3 was reviewed and it was determined the care plan had not been followed. The administrator state she had not been thinking about the incident as neglect at the time so she didn't think to report it. A facility policy Abuse and Neglect dated 3/31/22, indicated "alleged or suspected violations involving abuse, neglect..... will be reported immediately to the state agency, but no later than two hours after the allegation is made."	F 609	who to contact in the event of a reportable incident at any time including after hours. All direct care and nursing leadership staff will be educated on the policy requirements, form use, and reporting requirements. All incidents that require SA reporting will be reviewed by the GSS Clinical Consultant for further recommendation(s) if needed for immediate intervention. 4) How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The Quality Assurance Nurse will audit all incidents, data sources such as 24 hour progress note report and EMR Dashboard to ensure SA reportable incidents are reported in a timely manner. In addition, audits will include staff understanding and use of the incident reporting checklist. Audits will be conducted 5 x weekly for one week, 3 x weekly for 4 weeks, and 1 x weekly for 4 weeks. Audit results will be reported to the QAPI committee for further review. 5) The date for correction and the title of the person responsible for correction of deficiency. Date of correction will be 7/19/2022.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		7/19/22

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 06/29/2022

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 689	Continued From page 4 §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 interview and document review, the facility failed to The facility failed to provide adequate supervision by appropriately trained staff when a home maker (HM-A) staff assisted a resident, not utilizing care planned interventions and resulting in a fall with fracture. This had the potential to affect all residents in the facility that required assistance from staff for ambulation. In addition, the facility failed to implement care planned interventions for 1 of 3 residents (R3). The immediate jeopardy began on 6/20/22, when an unlicensed/non-certified (HM-A) staff assisted R1 to the bathroom while not utilizing care planned interventions resulting in a fall with fracture. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 4:00 pm. on 6/28/22. The immediate jeopardy was removed on 6/29/22, but noncompliance remained at the lower scope and severity of a D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. R1's Admission Record indicated he admitted to the facility on 3/1/22, with diagnosis that included cognitive deficits and repeated falls. R1's quarterly Minimum Data Set dated 6/2/22, identified moderately impaired cognition. R1's care plan dated 3/4/22, indicated he was able to	F 689	Deficiency tag…F689……. …… 1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R3 has been identified as a resident needing assist from certified/licensed personnel for locomotion, transfer and toileting ADL's. R3's Care Plan has been reviewed and revised to reflect the resident's need for assist. Education of all Homemaker, certified/licensed staff was conducted to identify this resident's care plan changes. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The facility has identified those residents who are at risk for serious adverse outcomes as any resident who resides in the facility. Those residents who reside in the facility have had their transfer and locomotion assistance needs evaluated by PT/OT and a current list has been devised. Any resident who is identified as needing physical assist to ambulate to and from activities or to any location will be provided assistance by appropriately	

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 06/29/2022

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 689	Continued From page 5 ambulate with assitance from one staff and a gait belt. A report to the state agency dated 6/21/22, indicated on 6/2/22, R1 had attended an activity off the unit and needed to use the bathroom. HM-A assisted R1 to a public bathroom and left him alone. About a minute later HM-A heard R1 fall and start to yell so she entered the bathroom and found R1 on the floor. R1 complained of pain rated 10/10 to his right shoulder and was sent to the emergency room where he was diagnosis with a right shoulder fracture. The resident had been assisted by a staff, but it was a HM who was not certified nursing assistant. The report indicated it was unlikely HM-A had used a gait belt when assisting R1 to the bathroom as directed by his care plan. A Progress Note dated 6/22/22, indicated the facility high risk committee met to review R1's fall. Fall intervention included NA staff only to assist with ambulation and must wear a gait belt. During interview on 6/27/22, At 4:15 p.m. the administrator stated falls were reviewed daily. The administrator stated immediate interventions were reviewed at that time. The administrator stated during the review the team looked at if the care plan had been followed at the time of the fall and if the care plan needed updating. The administrator stated when they discussed R1's incident the team determined they needed to talk to the staff and stated the HM role was newer to the facility. The administrator stated assisting residents to the bathroom was not part of HM-A's job as she was not trained to provide toileting assistance. The administrator stated the facility did not have a clear description of the HM's role	F 689	trained staff or certified/licensed personnel. The facility will provide either certified/licensed personnel present at activities off the unit or when transport is needed, or the ability to summon certified/licensed personnel via the utilized walkie talkie system. 3) What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Education of all Homemaker, certified/licensed staff will be conducted at the start of each shift with written notification by DON or designee until all staff are educated on updated procedures for transfer and locomotion assistance requirements. This will begin June 29, 2022 and continue until all staff are educated. Education will be provided to all staff at the start of each shift on the following: a. Locating and reviewing the Kardex in EMR b. Understanding how the resident transfers by reviewing the header titled Mobility/Transfers. c. Educate NAR staff on Homemaker role in locomotion assistance. d. Review of the list of residents who transfer/ambulate with assist of 1 staff and gait belt to and from activities or on and off the unit. e. Appropriate transport of a resident via wheelchair. f. Review of policy for Gait Belt use and Ambulation with certified/licensed staff. g. Importance of following the resident	

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 06/29/2022

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 689	Continued From page 6 in the facility and acknowledged HM-A would not have known which residents she could or could not assist. The administrator stated HM-A would not have known the level of assistance R1 required as she had not been trained to use the Kardex (nursing assistant care guide). The administrator stated herself and the DON were planning to do some education later in the week so HM staff would know who they could help and in what way. The administrator stated the HM's needed education on how they could transfer and use of the Walkie-talkies to communicate with the NA's. The administrator stated, following the incident on 6/20/22, HM-A continued to work with residents but had not received any additional training or guidance related to her position and stated she had just connected with HM-A that morning. The administrator stated at the time of the incident HM-A was the only staff member at the activity. The DON who was also present stated the HM's received on-boarding training and one to one with other HM's on the floor. The administrator stated she had reviewed HM-As file and said HM-A did not have and training related to safe resident handling. Review of HM-A's Job Description Summary, signed 10/21/21, indicated tasks such as food preparation and dining, assist with meals and snacks, provides water, housekeeping and laundry but the job description summary also reflected the "Nursing Assistant provides assistance with basic health care needs including daily actives that may include but not limited to bathing, toileting, grooming..... Assists the resident in transferring, repositioning, and walking using the correct and appropriate transfer techniques and equipment and also provides range of motion and passive exercises."	F 689	Kardex. h. Review and sign the list of Homemaker duties with Homemaker staff. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. 4. Audits of the following will be conducted daily for each activity x 1 week, then 3 x weekly x 4 weeks, then weekly ongoing x 12 weeks. a. Audits of transport to/from the activity conducted is appropriate. b. Certified/licensed personnel is present at the activity or able to be summoned via the facility walkie talkie system. c. Staff can state understanding of resident specific needs for transport based on the care plan. d. Staff can demonstrate how to look up the resident transfer needs in the Kardex. e. Findings of audits will be reported to the QAPI committee until adequate compliance is achieved, or x 3 months, whichever is greater. 4) The date for correction and the title of the person responsible for correction of deficiency. Date of correction will be 7/19/2022.	

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 06/29/2022

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 689	Continued From page 7 On 6/27/22, at 5:01 p.m. HM-A stated she had assisted R1 to the bathroom and confirmed she had not used a transfer/gait belt. HM-A stated other staff asked her to bring people to activities all the time and she had been doing what she was asked to do. HM-A stated at the time of the incident she was not aware she wasn't supposed to bring R1 to the bathroom. HM- stated she did not have access to the Kardex. HM-A stated after speaking with the administrator earlier today she "sort of" knew who she could assist. On 6/28/22, at 9:50 a.m. nursing assistant (NA)-A and NA-B were interviewed. NA-B stated the HM's role was to clean, get food and do activities on the units. NA-B stated the NA's brought residents to the of unit activities so the NAs could stay on the unit with the residents who did not attend. NA-A stated she was not aware of any residents on the unit that could not be escorted off unit by a HM. On 6/28/22, at 10:02 a.m. HM-B stated she was able to escort residents to activities but could not use a lift. HM-B stated she was not aware of anyone she could not escort to an activity. HM-B stated typically it was only HM's in the off site activities and said she did not usually carry a Walkie-talkie. On 6/28/22, at 10:07 a.m. HM-C stated she helped with meals, cleaned rooms and assisted residents to activities. HM-C stated if a resident used a walker they could escort them to an activity. HM-C stated there was typically only one HM in the off site activities. A facility policy Competency and Mandatory	F 689		

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 06/29/2022

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 689	Continued From page 8 Education Requirements dated 10/15/19, identified competence as the ability of an individual to perform a skill or a job properly. Ongoing measurement of competency is a process and an expectation of the employee. Sanford is responsible to provide processes for ongoing education and competency achievement. The immediate jeopardy began on 6/20/22 was removed on 6/29/22, at 2:55 p.m. when it was verified through interview and document review the facility had assesses supervision needs and policies related to care needs, updated job description for HM's and educated all staff on the scope of practice for the HM role in relation to resident care/supervision. In additional the facility educated staff on the use of the resident care guides and implemented a system to alert certified/licensed staff of resident needs when supervised only by HM's. R3's Admission Record indicated she admitted to the facility on 10/5/21, with diagnosis that included dementia and a history of falls. R3's quarterly MDS dated 4/14/22, identified severe cognitive impairment and indicated she required limited physical assistance from staff for transfers and ambulation. R3's care plan dated 4/9/22, identified a self care deficit. The care plan indicated a risk for falls related to confusion and a history of falls including a history of falls with fractures prior to admission to the facility. The care plan directed staff to ensure proper footwear, place a stop sign outside door and close door when R3 was not in her room, and indicated R3's wheel chair had been equipped with anti-roll backs for safety and fall prevention.	F 689		

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 06/29/2022

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 689	Continued From page 9 Progress Note dated 3/4/22, indicated the high risk committee met to discuss R3's fall that occurred on 2/25/22. The note indicated R3 attempted to stand and ambulate independently and fell in the dining room. The note indicated anti-roll backs were placed on R3's chair for safety and a stop sign was placed on her room door. A Falls Tool dated 6/20/20, indicated R3 had three or more falls in the past three months. The tool indicated R3 received two high risk medications and was moderately cognitively impaired. During observation on 6/27/22, at 1:52 p.m. R3 was seated in a wheel chair at a table in the common area of the unit. No anti-rollbacks were observed on her chair. R3's room was observed and the door to her room was open and no stop sign was placed on the door. At 1:56 p.m. NA-C stated R3 required limited assistance and stated R3 had not fallen in "quite some time." NA-C stated R3's fall interventions included a fall mat and a motion sensor. At 2:00 p.m. licensed practical nurse (LPN)-A stated staff kept and eye on R3 and tried to be aware of her movements. LPN-A verified R3 was seated in her own wheel chair and verified there were no anti-roll backs on the chair. NA-C stated the stop sign should have been placed across R3's door when she was out of the room and said staff did not want her in her room alone. At 4:15 p.m. the administrator stated falls were reviewed daily. The administrator stated immediate interventions were reviewed at that	F 689		

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 06/29/2022

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 689	Continued From page 10 time. The administrator stated during the review the team looked at if the care plan had been followed at the time of the fall and if the care plan needed updating. The administrator stated typically the registered nurse would follow up on implementation of interventions but stated it was everyone's responsibility. The administrator said she had not been aware R3 had a stop sign for her door. A facility policy related to following the plan of care was requested but not received.	F 689		

Electronically delivered
July 11, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: HMJ411

Dear Administrator:

The above facility was surveyed on June 27, 2022 through June 29, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
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 06/29/2022

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
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 6/27/22 - 6/29/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction 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 06/29/2022

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
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H53182887C (MN84493) 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 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.	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 06/29/2022

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
2 000	Continued From page 2 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 interview and document review, the facility failed to The facility failed to provide adequate supervision by appropriately trained staff when a home maker (HM-A) staff assisted a resident, not utilizing care planned interventions and resulting in a fall with fracture. This had the potential to affect all residents in the facility that required assistance from staff for ambulation. In addition, the facility failed to implement care planned interventions for 1 of 3 residents (R3). The immediate jeopardy began on 6/20/22, when an unlicensed/non-certified (HM-A) staff assisted	2 830	Corrected	7/19/22

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 06/29/2022

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
2 830	Continued From page 3 R1 to the bathroom while not utilizing care planned interventions resulting in a fall with fracture. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 4:00 pm. on 6/28/22. The immediate jeopardy was removed on 6/29/22, but noncompliance remained at the lower scope and severity of a D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. R1's Admission Record indicated he admitted to the facility on 3/1/22, with diagnosis that included cognitive deficits and repeated falls. R1's quarterly Minimum Data Set dated 6/2/22, identified moderately impaired cognition. R1's care plan dated 3/4/22, indicated he was able to ambulate with assitance from one staff and a gait belt. A report to the state agency dated 6/21/22, indicated on 6/2/22, R1 had attended an activity off the unit and needed to use the bathroom. HM-A assisted R1 to a public bathroom and left him alone. About a minute later HM-A heard R1 fall and start to yell so she entered the bathroom and found R1 on the floor. R1 complained of pain rated 10/10 to his right shoulder and was sent to the emergency room where he was diagnosis with a right shoulder fracture. The resident had been assisted by a staff, but it was a HM who was not certified nursing assistant. The report indicated it was unlikely HM-A had used a gait belt when assisting R1 to the bathroom as directed by his care plan. A Progress Note dated 6/22/22, indicated the facility high risk committee met to review R1's fall. Fall intervention included NA staff only to assist	2 830		

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 06/29/2022

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
2 830	Continued From page 4 with ambulation and must wear a gait belt. During interview on 6/27/22, At 4:15 p.m. the administrator stated falls were reviewed daily. The administrator stated immediate interventions were reviewed at that time. The administrator stated during the review the team looked at if the care plan had been followed at the time of the fall and if the care plan needed updating. The administrator stated when they discussed R1's incident the team determined they needed to talk to the staff and stated the HM role was newer to the facility. The administrator stated assisting residents to the bathroom was not part of HM-A's job as she was not trained to provide toileting assistance. The administrator stated the facility did not have a clear description of the HM's role in the facility and acknowledged HM-A would not have known which residents she could or could not assist. The administrator stated HM-A would not have known the level of assistance R1 required as she had not been trained to use the Kardex (nursing assistant care guide). The administrator stated herself and the DON were planning to do some education later in the week so HM staff would know who they could help and in what way. The administrator stated the HM's needed education on how they could transfer and use of the Walkie-talkies to communicate with the NA's. The administrator stated, following the incident on 6/20/22, HM-A continued to work with residents but had not received any additional training or guidance related to her position and stated she had just connected with HM-A that morning. The administrator stated at the time of the incident HM-A was the only staff member at the activity. The DON who was also present stated the HM's received on-boarding training and one to one with other HM's on the floor. The administrator stated she had reviewed HM-As file	2 830		

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 06/29/2022

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
2 830	Continued From page 5 and said HM-A did not have and training related to safe resident handling. Review of HM-A's Job Description Summary, signed 10/21/21, indicated tasks such as food preparation and dining, assist with meals and snacks, provides water, housekeeping and laundry but the job description summary also reflected the "Nursing Assistant provides assistance with basic health care needs including daily actives that may include but not limited to bathing, toileting, grooming..... Assists the resident in transferring, repositioning, and walking using the correct and appropriate transfer techniques and equipment and also provides range of motion and passive exercises." On 6/27/22, at 5:01 p.m. HM-A stated she had assisted R1 to the bathroom and confirmed she had not used a transfer/gait belt. HM-A stated other staff asked her to bring people to activities all the time and she had been doing what she was asked to do. HM-A stated at the time of the incident she was not aware she wasn't supposed to bring R1 to the bathroom. HM- stated she did not have access to the Kardex. HM-A stated after speaking with the administrator earlier today she "sort of" knew who she could assist. On 6/28/22, at 9:50 a.m. nursing assistant (NA)-A and NA-B were interviewed. NA-B stated the HM's role was to clean, get food and do activities on the units. NA-B stated the NA's brought residents to the of unit activities so the NAs could stay on the unit with the residents who did not attend. NA-A stated she was not aware of any residents on the unit that could not be escorted off unit by a HM. On 6/28/22, at 10:02 a.m. HM-B stated she was	2 830		

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 06/29/2022

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
2 830	Continued From page 6 able to escort residents to activities but could not use a lift. HM-B stated she was not aware of anyone she could not escort to an activity. HM-B stated typically it was only HM's in the off site activities and said she did not usually carry a Walkie-talkie. On 6/28/22, at 10:07 a.m. HM-C stated she helped with meals, cleaned rooms and assisted residents to activities. HM-C stated if a resident used a walker they could escort them to an activity. HM-C stated there was typically only one HM in the off site activities. A facility policy Competency and Mandatory Education Requirements dated 10/15/19, identified competence as the ability of an individual to perform a skill or a job properly. Ongoing measurement of competency is a process and an expectation of the employee. Sanford is responsible to provide processes for ongoing education and competency achievement. The immediate jeopardy began on 6/20/22 was removed on 6/29/22, at 2:55 p.m. when it was verified through interview and document review the facility had assesses supervision needs and policies related to care needs, updated job description for HM's and educated all staff on the scope of practice for the HM role in relation to resident care/supervision. In additional the facility educated staff on the use of the resident care guides and implemented a system to alert certified/licensed staff of resident needs when supervised only by HM's. R3's Admission Record indicated she admitted to the facility on 10/5/21, with diagnosis that included dementia and a history of falls. R3's quarterly MDS dated 4/14/22, identified severe	2 830		

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 06/29/2022

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
2 830	Continued From page 7 cognitive impairment and indicated she required limited physical assistance from staff for transfers and ambulation. R3's care plan dated 4/9/22, identified a self care deficit. The care plan indicated a risk for falls related to confusion and a history of falls including a history of falls with fractures prior to admission to the facility. The care plan directed staff to ensure proper footwear, place a stop sign outside door and close door when R3 was not in her room, and indicated R3's wheel chair had been equipped with anti-roll backs for safety and fall prevention. Progress Note dated 3/4/22, indicated the high risk committee met to discuss R3's fall that occurred on 2/25/22. The note indicated R3 attempted to stand and ambulate independently and fell in the dining room. The note indicated anti-roll backs were placed on R3's chair for safety and a stop sign was placed on her room door. A Falls Tool dated 6/20/20, indicated R3 had three or more falls in the past three months. The tool indicated R3 received two high risk medications and was moderately cognitively impaired. During observation on 6/27/22, at 1:52 p.m. R3 was seated in a wheel chair at a table in the common area of the unit. No anti-rollbacks were observed on her chair. R3's room was observed and the door to her room was open and no stop sign was placed on the door. At 1:56 p.m. NA-C stated R3 required limited assistance and stated R3 had not fallen in "quite some time." NA-C stated R3's fall interventions included a fall mat and a motion sensor.	2 830		

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 06/29/2022

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
2 830	Continued From page 8 At 2:00 p.m. licensed practical nurse (LPN)-A stated staff kept and eye on R3 and tried to be aware of her movements. LPN-A verified R3 was seated in her own wheel chair and verified there were no anti-roll backs on the chair. NA-C stated the stop sign should have been placed across R3's door when she was out of the room and said staff did not want her in her room alone. At 4:15 p.m. the administrator stated falls were reviewed daily. The administrator stated immediate interventions were reviewed at that time. The administrator stated during the review the team looked at if the care plan had been followed at the time of the fall and if the care plan needed updating. The administrator stated typically the registered nurse would follow up on implementation of interventions but stated it was everyone's responsibility. The administrator said she had not been aware R3 had a stop sign for her door. A facility policy related to following the plan of care was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and 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		

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 06/29/2022

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