Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 1, 2024

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

RE: CCN: 245318
Cycle Start Date: January 19, 2024

Dear Administrator:

On January 25, 2024, we notified you a remedy was imposed. On February 9, 2024 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 February 4, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 9, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 25, 2024, 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 February 9, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 4, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 1, 2024

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

Re: Reinspection Results
Event ID: FFTR12

Dear Administrator:

On February 9, 2024 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 January 19, 2024. 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
January 25, 2024

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

RE: CCN: 245318
Cycle Start Date: January 19, 2024

Dear Administrator:

On January 19, 2024, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 9, 2024.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 9, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 9, 2024.

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

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 9, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - International Falls will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 9, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

DEPARTMENT CONTACT

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

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 19, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and

1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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

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

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

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

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

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

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

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Electronically delivered
January 25, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: FFTR11

Dear Administrator:

The above facility was surveyed on January 18, 2024 through January 19, 2024 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
	245318	A. BUILDING _____ B. WING _____	C 01/19/2024

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 1/18/24 through 1/19/24 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 complaint was reviewed: H53188985C (MN99380) with a deficiency cited 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 689 SS=G	. 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 interview and document review the	F 689	Preparation and execution of this	2/4/24

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

Electronically Signed | 02/01/2024

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
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F 689	Continued From page 1 facility failed to ensure adequate supervision to reduce the risk of falls for 1 of 3 residents (R1) who had a history of falls with serious injury. This resulted in actual harm for R1 who fell and sustained a laceration to her head and a subdural hematoma (pool of blood between the brain and its outermost covering). In addition, the facility failed to develop a sustainable plan for ongoing supervision. Findings include: R1's quarterly Minimum Data Set (MDS) dated 11/29/23, identified severe cognitive impairment and indicated she was dependent on staff for transfers. The MDS indicated R1 did not have a fall since the prior assessment. R1's care plan dated 10/29/23, identified a communication problem related to dementia and a self care deficit. The care plan indicated R1 used a wheel chair with assistance from staff for locomotion and transferred using a mechanical lift. The care plan indicated R1 had a fall on 12/19/23, resulting in a subdural bleed. The care plan directed the use of a video monitoring device to observe movement when R1 was alone in her room, bed in lowest position and directed staff to remove the leg rests on her wheel chair when she was not being transported in the chair. R1's Kardex (care guide) dated 12/18/23, identified the following interventions: - Anti-thrust cushion with a calf rests. - Grippy tape at bedside and in front of chair. - When in wheel chair R1 must be in line of staff site. When not being pushed in wheelchair leg foot rests should be removed.	F 689	response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by the provision of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with the federal requirements of participation, the response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the state operations manual How corrective action will be accomplished for those residents found to be affected by the deficient practice. Resident R1 care plan was reviewed and updated. C.NA was immediately re-educated on following care plan and safety procedures for resident (R1) including proper supervision and wheelchair safety procedures. 12/27/24 IDT identified times when resident (R1) is at high risk for falls. Interventions have been put into place to assure proper supervision of resident during those times. IDT members met with family of (R1) on 12/19/24 to discuss safety concerns and fall interventions. Completed 12/21/24	

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F 689	Continued From page 2 A facility Fall Scene Huddle Worksheet dated 12/19/23, indicated at 4:45 p.m. R1 was found on the floor in the dining room. R1 was unable to state what she was trying to do. The worksheet indicated she had been brought to the dining room by staff approximately five minutes prior to the fall. The worksheet further indicated the wheelchair brakes were not locked. An untitled facility incident report dated 12/19/23, indicated a visitor reported to staff that R1 had fallen in the dining room and was bleeding. R1 was on the floor in the dining room next to her wheelchair and dining room table with a gash above her left eye brow. Predisposing factors indicated, not applicable. An undated, untitled review of the incident indicated on 12/19/23, R1 had an unwitnessed fall in the dining room and indicated R1 had mutliple falls since admission to the facility. Prior incidents included falls on 2/13/23 and 4/19/23, that resulted in injuries. R1 had shown an improvement in transfer ability and had recently been changed to a stand to pivot transfer. Contributing factors included the nursing assistant (NA) left R1 alone in the dining room. Advanced Alzheimer's disease with history of impulsive behavior, recent improvement in walking and transferring and discontinuation of Gabapentin may have contributed to R1 deciding to stand and walk unassisted. Plan for staff to monitor every 15 minutes as able, review of Kardex and paying attention to safety concerns, not locking wheelchair brakes at the table and not bringing residents who require supervision with eating to the table until staff are able to assist them.	F 689	OT will evaluate resident (R1) for wheelchair safety and positioning. How the facility will identify other residents having the potential to be affected by the same deficient practice All resident who have a history of falls with serious injury have the potential to be effected by this deficiency . DNS / designee will review resident care plans of all residents who have had falls with serious injury and assure care plans are resident specific and goals are attainable. What measures will be put into place, or systemic changes made to ensure the deficient practice will not occur Interdisciplinary team will meet weekly, or as needed, to review care plans and interventions of residents who are at high risk for falls and adjust as needed All nursing staff and interdisciplinary team members will receive education on resident specific care plans, interventions, change of condition, and communication/documentation for residents who are at high fall risk for fall with injury	

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F 689	Continued From page 3 R1's facility Progress Notes indicated on 12/19/23, staff was alerted by a visitor that R1 was on the floor in the dining room bleeding. R1 had a laceration on the right side of her head above her brow. Called ambulance. 12/19/23, Notified by hospital staff R1 had a subdural bleed and also nicked an artery that was sewn up along with seven to eight staples. 12/20/23, notified R1 would be returning to facility on comfort care. 12/21/23, R1 re-admitted to the facility following two night hospital stay after fall resulting in injury. 12/21/23, staff and family discussed R1's fall on 12/19/23. R1 was brought to the dining room for dinner and two minutes later she stood up and began walking along the table. As soon as she let go of the table R1 fell striking her head on the floor. R1 was alone in the dining room at the time as the two staff members were assisting others. Family expressed frustration with R1's fall and wanted to discuss interventions. Family asked why R1 did not have alarms and writer explained the reasons these devices were no longer allowed. Family thought R1 should have a chair and a bed alarm due to her high fall risk. Also discussed was having a lap buddy (designed to provide anterior posture support while safely securing the resident in a seated position) on her wheelchair to distract her from standing. Writer explained in detail what were considered restraints. Family still requested writer get a physician's order for the lap buddy and stated they would sign a consent. Other interventions discussed: R1 would be checked on every 15 minutes as staff were able, R1 would no longer be brought and left alone at dining room table, motion sensor placed in room and family requested video monitoring device in room. Progress Notes dated 12/22/23 through 1/17/24, identified multiple attempts by R1 to stand up	F 689	How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not occur DNS or designee will perform random audits of care plan compliance for resident who are high risk for falls with injury 5 x per week x 46 weeks, then will receive recommendation from QAPI committee on the continuation and frequency of audits based on results. All findings from IDT audits will be reported to the Quality Assurance Action Committee (QAPI) monthly for recommendation and further action as needed. The Director of Nursing will be responsible for this plan of correction Date of completion: 2/4/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 4 from her wheel chair. Emergency Department (ED) Provider Notes dated 12/19/23, indicated R1 was brought to the ED after a fall out of her wheelchair at the nursing home. R1 had a large laceration over her left temporal area. Computed Tomography (CT) identified a fairly extensive left subdural hematoma that extended along the temporal lobe. Procedures included a laceration repair of R1's forehead that included 11 sutures and closed with staples. After CT results were reviewed, call was placed to hospital in Duluth to discuss case with trauma surgeon. Trauma surgery would not perform any procedure on R1 to relieve pressure or evacuate bleeding due to her being on Plavix (blood thinner) and physician stated any procedure may make the bleeding worse. Conversation with family to forgo transfer to higher level of care and admit for comfort cares. During interview on 1/18/24 at 4:30 p.m., NA-A stated when R1 fell on 12/19/23, she got R1 up for dinner around 4:30 p.m. NA-A said she had five other residents to get up so she brought R1 to the table and put the wheel chair brake on. NA-A stated she left R1's foot pedals on while she was at the table and said she was not aware she was supposed to remove them. NA-A said after leaving R1 at the table she went to another room and when she came out R1 was on the floor. On 1/18/24 at 5:21 p.m., family members (FM)-A and FM-B were interviewed. FM-A stated "this last fall, we were afraid we were going to lose her [R1]". FM-A said the facility did not want them to look at the video and said R1 was on blood thinner and "bleeding horribly" and said she had	F 689		

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	245318	A. BUILDING _____ B. WING _____	C 01/19/2024

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

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F 689	Continued From page 5 internal stitches and external staples. FM-A said the prognosis was not good because R1's brain was so full of the brain bleed. FM-A said they chose to put R1 on comfort care. FM-B said they had concerns, not just about the falls but the staffing. FM-B said they were at the facility every day for about two hours. FM-A said right after the fall it, "shook things up" but said, "I already see it sliding back." FM-B stated in regard to R1's fall, "I think the bottom line is it comes down to staffing." During interview on 1/19/24 at 9:09 a.m., licensed practical nurse (LPN)-A stated when R1 fell on 12/19/23, she had left the unit to get something and said the NA's must have been in rooms. LPN-A said a visitor found R1 and said R1 was lying flat on her back. LPN-A said the foot pedals were still on the wheel chair and the wheelchair looked like it had been pushed back and R1 was next to the table. LPN-A stated the staffing was pretty short on evenings and weekends and said it was not reasonable to be able to watch everyone. LPN-A said a video monitor was implemented while R1 was in bed but said R1 did not fall when in bed. During interview on 1/19/24 at 9:19 a.m., NA-B stated R1 used to walk but refused to use a walker so staff kept an eye on her. NA-B said R1 was "pretty stable" at that time. NA-B said R1 had a pretty bad fall a while back and then she required a wheelchair and a mechanical lift for transfers. NA-B said R1's fall interventions included keeping the bed in the lowest position and keep a flat pad call light next to her to alert staff of movement in bed. NA-B said when R1 was in the wheelchair staff were supposed to sit with her and keep an eye on her but said it was not uncommon for her to be the only NA on the	F 689		

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F 689	Continued From page 6 unit. During interview on 1/19/24 at 9:30 a.m., NA-C stated R1 thought she could walk by herself and had nothing to hold onto then fell. NA-C stated staff tried to make sure R1 had something in her hands and said she had a blanket with "busy items." NA-C stated since R1's fall on 12/19/23, someone had to be with her at all times when she was out of bed. NA-C said a lot of times the unit was staffed with just herself and a nurse and said "I cannot reasonably stay with her with one person" and said even with two NA's it was hard. During interview on 1/19/24 at 1:13 p.m., registered nurse (RN)-A stated on 12/19/23, a NA who did not always work on the unit brought R1 to the dining room at around 4:40 p.m. RN-A said the home maker on the unit left to go get food and R1 stood up. RN-A stated they reviewed the video footage and R1 had pushed herself up and tipped over sideways to her left side. RN-A said the very first person who saw R1 was another resident, then a visitor came out of a room and started yelling. RN-A stated a week before R1's fall her Gabapentin had been discontinued and R1 had been more awake and alert since. RN-A stated they had placed a video camera in R1's room and the nurse kept the monitor on the cart at all times. RN-A said they had been doing 15 minute checks but determined it was not sustainable. RN-A stated she told the NA's R1 should be the last person up and staff should not bring her to the table until someone was ready to feed her but said a lot of times there was just one NA on the unit. RN-A said staff can't keep her in their sight line and said if there was only one NA, "I don't know how they could properly supervise her." Every time staff needed a two person	F 689		

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F 689	Continued From page 7 transfer or an alarm went off the nurse got pulled away from the cart. During interview on 1/19/24 at 12:02 p.m., RN-B stated the video camera was implemented because family wanted 15 minute checks and that was not manageable. When asked about the addition of the video camera in the room in relation to R1's fall in the dining room, RN-B said "I don't know." RN-B stated staff were not able to adequately supervise R1 and said if a NA was in a room and the nurse was in a med room there was no one to watch R1. RN-B stated R1's falls typically occurred in the evenings before family arrived or after family left. During interview on 1/19/24 at 1:00 p.m. the interim administrator stated one of the issues in the facility was the ability to afford good staff and said a wage increase had been approved and they were hoping that would help. The interim administrator stated they had contacted staffing agencies to try to find staff for the facility. The interim administrator stated he identified the current staffing levels did not meet the needs of the residents. A facility policy related to fall interventions was requested but not received.	F 689		

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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 1/18/24 through 1/19/24, 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		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H53188985C (MN99380) 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		

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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 ensure adequate supervision to reduce the risk of falls for 1 of 3 residents (R1) who had a history of falls with serious injury. This resulted in actual harm for R1 who fell and sustained a laceration to her head and a subdural hematoma (pool of blood between the brain and its outermost covering). In addition, the facility failed to develop a sustainable plan for ongoing supervision. Findings include:	2 830	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by the provision of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with the federal requirements of participation, the response and plan of correction	2/4/24

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2 830	Continued From page 3 R1's quarterly Minimum Data Set (MDS) dated 11/29/23, identified severe cognitive impairment and indicated she was dependent on staff for transfers. The MDS indicated R1 did not have a fall since the prior assessment. R1's care plan dated 10/29/23, identified a communication problem related to dementia and a self care deficit. The care plan indicated R1 used a wheel chair with assistance from staff for locomotion and transferred using a mechanical lift. The care plan indicated R1 had a fall on 12/19/23, resulting in a subdural bleed. The care plan directed the use of a video monitoring device to observe movement when R1 was alone in her room, bed in lowest position and directed staff to remove the leg rests on her wheel chair when she was not being transported in the chair. R1's Kardex (care guide) dated 12/18/23, identified the following interventions: - Anti-thrust cushion with a calf rests. - Grippy tape at bedside and in front of chair. - When in wheel chair R1 must be in line of staff site. When not being pushed in wheelchair leg foot rests should be removed. A facility Fall Scene Huddle Worksheet dated 12/19/23, indicated at 4:45 p.m. R1 was found on the floor in the dining room. R1 was unable to state what she was trying to do. The worksheet indicated she had been brought to the dining room by staff approximately five minutes prior to the fall. The worksheet further indicated the wheelchair brakes were not locked. An untitled facility incident report dated 12/19/23, indicated a visitor reported to staff that R1 had fallen in the dining room and was bleeding. R1 was on the floor in the dining room next to her	2 830	constitutes the centers allegation of compliance in accordance with section 7305 of the state operations manual How corrective action will be accomplished for those residents found to be affected by the deficient practice. Resident R1 care plan was reviewed and updated. C.NA was immediately re-educated on following care plan and safety procedures for resident (R1) including proper supervision and wheelchair safety procedures. 12/27/24 IDT identified times when resident (R1) is at high risk for falls. Interventions have been put into place to assure proper supervision of resident during those times. IDT members met with family of (R1) on 12/19/24 to discuss safety concerns and fall interventions. Completed 12/21/24 OT will evaluate resident (R1) for wheelchair safety and positioning. How the facility will identify other residents having the potential to be affected by the same deficient practice All resident who have a history of falls with serious injury have the potential to be effected by this deficiency	

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2 830	Continued From page 4 wheelchair and dining room table with a gash above her left eye brow. Predisposing factors indicated, not applicable. An undated, untitled review of the incident indicated on 12/19/23, R1 had an unwitnessed fall in the dining room and indicated R1 had mutliple falls since admission to the facility. Prior incidents included falls on 2/13/23 and 4/19/23, that resulted in injuries. R1 had shown an improvement in transfer ability and had recently been changed to a stand to pivot transfer. Contributing factors included the nursing assistant (NA) left R1 alone in the dining room. Advanced Alzheimer's disease with history of impulsive behavior, recent improvement in walking and transferring and discontinuation of Gabapentin may have contributed to R1 deciding to stand and walk unassisted. Plan for staff to monitor every 15 minutes as able, review of Kardex and paying attention to safety concerns, not locking wheelchair brakes at the table and not bringing residents who require supervision with eating to the table until staff are able to assist them. R1's facility Progress Notes indicated on 12/19/23, staff was alerted by a visitor that R1 was on the floor in the dining room bleeding. R1 had a laceration on the right side of her head above her brow. Called ambulance. 12/19/23, Notified by hospital staff R1 had a subdural bleed and also nicked an artery that was sewn up along with seven to eight staples. 12/20/23, notified R1 would be returning to facility on comfort care. 12/21/23, R1 re-admitted to the facility following two night hospital stay after fall resulting in injury. 12/21/23, staff and family discussed R1's fall on 12/19/23. R1 was brought to the dining room for dinner and two minutes later she stood up and	2 830	. DNS / designee will review resident care plans of all residents who have had falls with serious injury and assure care plans are resident specific and goals are attainable. What measures will be put into place, or systemic changes made to ensure the deficient practice will not occur Interdisciplinary team will meet weekly, or as needed, to review care plans and interventions of residents who are at high risk for falls and adjust as needed All nursing staff and interdisciplinary team members will receive education on resident specific care plans, interventions, change of condition, and communication/documentation for residents who are at high fall risk for fall with injury How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not occur DNS or designee will perform random audits of care plan compliance for resident who are high risk for falls with injury 5 x per week x 46 weeks, then will receive recommendation from QAPI committee on the continuation and frequency of audits based on results.	

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2 830	Continued From page 5 began walking along the table. As soon as she let go of the table R1 fell striking her head on the floor. R1 was alone in the dining room at the time as the two staff members were assisting others. Family expressed frustration with R1's fall and wanted to discuss interventions. Family asked why R1 did not have alarms and writer explained the reasons these devices were no longer allowed. Family thought R1 should have a chair and a bed alarm due to her high fall risk. Also discussed was having a lap buddy (designed to provide anterior posture support while safely securing the resident in a seated position) on her wheelchair to distract her from standing. Writer explained in detail what were considered restraints. Family still requested writer get a physician's order for the lap buddy and stated they would sign a consent. Other interventions discussed: R1 would be checked on every 15 minutes as staff were able, R1 would no longer be brought and left alone at dining room table, motion sensor placed in room and family requested video monitoring device in room. Progress Notes dated 12/22/23 through 1/17/24, identified multiple attempts by R1 to stand up from her wheel chair. Emergency Department (ED) Provider Notes dated 12/19/23, indicated R1 was brought to the ED after a fall out of her wheelchair at the nursing home. R1 had a large laceration over her left temporal area. Computed Tomography (CT) identified a fairly extensive left subdural hematoma that extended along the temporal lobe. Procedures included a laceration repair of R1's forehead that included 11 sutures and closed with staples. After CT results were reviewed, call was placed to hospital in Duluth to discuss case with trauma surgeon. Trauma surgery would not perform any procedure on R1	2 830	All findings from IDT audits will be reported to the Quality Assurance Action Committee (QAPI) monthly for recommendation and further action as needed. The Director of Nursing will be responsible for this plan of correction Date of completion: 2/4/24	

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2 830	Continued From page 6 to relieve pressure or evacuate bleeding due to her being on Plavix (blood thinner) and physician stated any procedure may make the bleeding worse. Conversation with family to forgo transfer to higher level of care and admit for comfort cares. During interview on 1/18/24 at 4:30 p.m., NA-A stated when R1 fell on 12/19/23, she got R1 up for dinner around 4:30 p.m. NA-A said she had five other residents to get up so she brought R1 to the table and put the wheel chair brake on. NA-A stated she left R1's foot pedals on while she was at the table and said she was not aware she was supposed to remove them. NA-A said after leaving R1 at the table she went to another room and when she came out R1 was on the floor. On 1/18/24 at 5:21 p.m., family members (FM)-A and FM-B were interviewed. FM-A stated "this last fall, we were afraid we were going to lose her [R1]". FM-A said the facility did not want them to look at the video and said R1 was on blood thinner and "bleeding horribly" and said she had internal stitches and external staples. FM-A said the prognosis was not good because R1's brain was so full of the brain bleed. FM-A said they chose to put R1 on comfort care. FM-B said they had concerns, not just about the falls but the staffing. FM-B said they were at the facility every day for about two hours. FM-A said right after the fall it, "shook things up" but said, "I already see it sliding back." FM-B stated in regard to R1's fall, "I think the bottom line is it comes down to staffing." During interview on 1/19/24 at 9:09 a.m., licensed practical nurse (LPN)-A stated when R1 fell on 12/19/23, she had left the unit to get something and said the NA's must have been in rooms. LPN-A said a visitor found R1 and said R1 was	2 830		

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

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2 830	Continued From page 7 lying flat on her back. LPN-A said the foot pedals were still on the wheel chair and the wheelchair looked like it had been pushed back and R1 was next to the table. LPN-A stated the staffing was pretty short on evenings and weekends and said it was not reasonable to be able to watch everyone. LPN-A said a video monitor was implemented while R1 was in bed but said R1 did not fall when in bed. During interview on 1/19/24 at 9:19 a.m., NA-B stated R1 used to walk but refused to use a walker so staff kept an eye on her. NA-B said R1 was "pretty stable" at that time. NA-B said R1 had a pretty bad fall a while back and then she required a wheelchair and a mechanical lift for transfers. NA-B said R1's fall interventions included keeping the bed in the lowest position and keep a flat pad call light next to her to alert staff of movement in bed. NA-B said when R1 was in the wheelchair staff were supposed to sit with her and keep an eye on her but said it was not uncommon for her to be the only NA on the unit. During interview on 1/19/24 at 9:30 a.m., NA-C stated R1 thought she could walk by herself and had nothing to hold onto then fell. NA-C stated staff tried to make sure R1 had something in her hands and said she had a blanket with "busy items." NA-C stated since R1's fall on 12/19/23, someone had to be with her at all times when she was out of bed. NA-C said a lot of times the unit was staffed with just herself and a nurse and said "I cannot reasonably stay with her with one person" and said even with two NA's it was hard. During interview on 1/19/24 at 1:13 p.m., registered nurse (RN)-A stated on 12/19/23, a NA who did not always work on the unit brought R1 to	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 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 8 the dining room at around 4:40 p.m. RN-A said the home maker on the unit left to go get food and R1 stood up. RN-A stated they reviewed the video footage and R1 had pushed herself up and tipped over sideways to her left side. RN-A said the very first person who saw R1 was another resident, then a visitor came out of a room and started yelling. RN-A stated a week before R1's fall her Gabapentin had been discontinued and R1 had been more awake and alert since. RN-A stated they had placed a video camera in R1's room and the nurse kept the monitor on the cart at all times. RN-A said they had been doing 15 minute checks but determined it was not sustainable. RN-A stated she told the NA's R1 should be the last person up and staff should not bring her to the table until someone was ready to feed her but said a lot of times there was just one NA on the unit. RN-A said staff can't keep her in their sight line and said if there was only one NA, "I don't know how they could properly supervise her." Every time staff needed a two person transfer or an alarm went off the nurse got pulled away from the cart. During interview on 1/19/24 at 12:02 p.m., RN-B stated the video camera was implemented because family wanted 15 minute checks and that was not manageable. When asked about the addition of the video camera in the room in relation to R1's fall in the dining room, RN-B said "I don't know." RN-B stated staff were not able to adequately supervise R1 and said if a NA was in a room and the nurse was in a med room there was no one to watch R1. RN-B stated R1's falls typically occurred in the evenings before family arrived or after family left. During interview on 1/19/24 at 1:00 p.m. the interim administrator stated one of the issues in	2 830		

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2 830	Continued From page 9 the facility was the ability to afford good staff and said a wage increase had been approved and they were hoping that would help. The interim administrator stated they had contacted staffing agencies to try to find staff for the facility. The interim administrator stated he identified the current staffing levels did not meet the needs of the residents. A facility policy related to fall interventions 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 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		