DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 23, 2023

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

RE: CCN: 245318
Cycle Start Date: December 2, 2022

Dear Administrator:

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

As authorized by CMS the remedy of:

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

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 Therefore, the NATCEP prohibition is rescinded.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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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Electronically delivered

March 23, 2023

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

Re: Reinspection Results
Event ID: ZQNK12

Dear Administrator:

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 21, 2022

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

RE: CCN: 245318
Cycle Start Date: December 2, 2022

Dear Administrator:

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

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

REMEDIES

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

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

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

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

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 20, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - International Falls will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 20, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

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

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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

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

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

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

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204 Fax: (651) 215-0525
Email: william.abderhalden@state.mn.us

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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 12/02/2022

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
E 000	Initial Comments On 11/28/22 through 12/2/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/28/22 through 12/2/22, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. 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 H53186033C (MN87700) was found to be SUBSTANTIATED; however, no deficiencies were cited due to actions taken by the facility. The following complaints were found to be UNSUBSTANTIATED: H53185928C (MN87574) H5318043C (MN79875) H53185929C (MN85414) H53186026C (MN86687) H53186027C (MN86440) H53186028C (MN85379) H53186029C (MN85250) H53186030C (MN85252)	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/30/2022

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

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F 000	Continued From page 1 H53186031C (MN85328) H53186032C (MN85788) 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 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to review for and/or complete a significant change in status assessment (SCSA) when two or more areas of change in resident status were identified for 1 of 5 resident (R34)	F 637	F637 1. How corrective action will be accomplished for those residents found to have been affected by the deficient	1/17/23

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F 637	Continued From page 2 reviewed for activities of daily living. Findings include: R34's quarterly Minimum Data Set (MDS) dated 6/21/22, identified R34 had severe cognitive impairment and diagnoses included femur fracture with joint replacement surgery, cognitive communication deficiency and heart disease. R34 was independent with transfers and ambulation in the room and required supervision with bed mobility, grooming, dressing, toileting and ambulation in the corridor. During interview on 12/1/22, at 10:03 a.m. registered nurse (RN)-B stated in September of 2022, R34 had a fall that resulted in a fracture and R34 had significant decline in ADL's During interview on 12/2/22, at 11:04 a.m. the director of nursing (DON) stated staff complete a significant change MDS when a resident had two changes and the resident was not expected to recover from the changes. R34 had a fall with fracture in September 2022, and upon return from the hospital R34 started and completed physical therapy. The DON stated a significant change MDS should have been completed when R34 finished physical therapy as R34 never returned to baseline. The facilities MDS Resident Assessment Instrument (RAI) policy reviewed 6/6/22 identified a significant change assessment should be completed upon identification of the residents change. The Minimum Data Set 3.0 Manual V1.17.1 dated 10/19, identified assessment Management	F 637	practice. R34 should have had a SCSA completed after it was determined that she would not return to her baseline performance. A significant change was completed on December 1, 2022. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. Any residents who were hospitalized or receiving therapy services in the past 30 days will be reviewed for potential SCSA and complete as indicated. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. IDT will be re-educated on the Chapter 2 pages 2-22 through 2-29 of the RAI manual as well as the Good Samaritan Policy and Procedure titled MDS 3.0 page 4 under Procedure: Significant Change MDS. IDT will review residents ongoing for potential SCSA at weekly Medicare Meeting. Any resident on the agenda for high risk committee review will be considered weekly for SCSA. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Any residents who were hospitalized or receiving therapy services will be audited for SCSA completion as indicated 1 x per week x 4 weeks, 2 x per month x 1 month, then monthly x 3 months. Results of audits will be submitted to QAPI monthly x 3 to ensure compliance and reassessed for further	

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F 637	Continued From page 3 Requirements and Tips for Significant Change in Status Assessments: A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident current status to the most recent comprehensive assessment and any subsequent quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks. Guidelines for Determining a Significant Change in Resident Status: The final decision what constitutes a significant change in status must be based upon the judgment of the IDT (interdisciplinary team). MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within two weeks. However, staff must note these transient changes in the resident status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required. Some Guidelines to Assist in Deciding If a Change is Significant or Not: Decline in two or more of the following: Any decline in an ADL physical functioning area where a resident is newly coded as extensive assistance, total dependence, or activity did not occur; Resident incontinence pattern changes or there was placement of an indwelling catheter.	F 637	action.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		1/17/23

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F 677	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine grooming and personal hygiene to 1 of 5 residents (R4) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R4's quarterly Minimum Data Set (MDS) dated 11/15/22, identified R4 had severe cognitive impairment and was totally dependent on staff for personal hygiene and bathing. R4's care plan dated 10/10/22, identified R4 required total assistance with grooming, and incontinence care, with a goal that R4 would maintain ADL function with staff assistance. On 11/30/22, at 6:45 a.m. R4's morning care was observed with nursing assistant (NA)-A and NA-B. NA-A removed bed sheet and checked R4's brief to see if it was wet or soiled. She stated R4's brief was dry and closed the brief. NA-A went to the closet to obtain R4's clothing. Both NA's assisted R4 to dress and placed the lift sheet underneath him. They transferred R4 into his chair using the mechanical lift. NA-A combed R4's hair and NA-B put on his shoes. NA-A turned R4's wheel chair in front of the television, secured his call light to his shirt and exited the room. The NA's did not provide any partial bed bath or peri care. When interviewed on 11/30/22, at 7:00 a.m. NA-A stated they did not do bed baths and only provided peri care when the resident was	F 677	F677 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R4 has expired due to conditions unrelated to deficiency. Resident□s ADL care plan was reviewed prior to his passing and was appropriate for his care. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. Director of Nursing, Quality Specialist or designee; will review all care plans of dependent residents to ensure activities of daily living are appropriately completed and specific to resident. Each care plan will include AM/PM care interventions, i.e., perineal care, grooming and personal hygiene which will flow to the point of care to guide nursing staff. Audits will be completed by the Director of Nursing or designee to verify compliance. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. All nursing staff will attend an in-service educating them on activities of daily living, focusing on what should be offered/completed for every resident in the morning and evening cares. Director of Nursing will create a generalized list of duties for AM/PM cares for all NA-C. This will be provided to current employees and a copy will be placed in our NA-C and NA new hire packet.	

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F 677	Continued From page 5 incontinent. They did not wash or dry resident with morning cares or provide any lotion to their skin. That was all done on the resident's bath day and it was not R4's bath day. During interview on 12/2/22, at 9:00 a.m. NA-C stated she assisted R4 to get up the morning of 12/2/22. NA-C assisted R4 with a partial bath, using a warm basin of warm soapy water. R4 liked the water slightly soapy with his morning partials and was fully cooperative with morning care. She washed and dried his torso, back and peri area and applied lotion to his back. She felt R4 enjoyed his morning partials and she could not think of a time he ever refused it or resisted it. When interviewed on 12/2/22, at 10:30 a.m. licensed practical nurse (LPN)-A stated the NA's typically assisted residents with a partial bath when getting them up for the day. A partial bath would include washing a residents back and peri area and was done daily when getting the resident up for the day. It was done daily and not just on bath day. It would be a concern if the NA's were not assisting residents with a partial daily. During interview on 12/2/22, at 11:30 a.m. the director of nursing stated she expected all dependent residents to receive a partial bath when assisting them to get up for the day. She found some of the newer NA's needed to be reminded of this and she was planning on doing more training with them regarding the issue. The facility policy Activities of Daily Living reviewed 11/29/22, identified any resident who was unable to carry out activities of daily living would receive necessary services to maintain	F 677	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. To monitor performance and ensure that solutions are sustained the Director of Nursing, Quality Specialist or designee; will audit AM/PM grooming and personal care on 3 random dependent residents daily X2 weeks, 3X/week for 2 weeks, 1X/week for 4 weeks then 1x per month for 3 months until compliance is sustained. The results will be brought to the monthly QAPI meeting for review and/or further recommendations.	

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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 677	Continued From page 6 good nutrition, grooming and personal and oral hygiene. ADLs are necessary tasks conducted in the the normal course of a resident's daily life and included general personal and daily hygiene and grooming.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to apply a hand splint for 1 of 3 residents (R28) reviewed for range of motion services. Findings include: R28's significant change Minimum Data Set (MDS) dated 11/28/22, identified severe cognitive impairment and was totally dependent on staff for	F 688	F688 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Review of R28 care plan was completed for accuracy and clarification/education provided to staff on usage of hand splint. 2. How the facility will identify other	1/17/23

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 12/02/2022

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F 688	Continued From page 7 her activities of daily living. R28 was identified to be on a restorative nursing program and utilized a splint. R28's care plan dated 10/26/22, identified R28 required assistance with a left resting hand splint. R28 was to wear left resting hand splint all day besides mealtime and activities. R28's occupational therapy noted dated 10/28/22, identified R28 was tolerating splint used for left hand positioning and no further changes were required at this time. During observation on 11/29/22, at 8:16 a.m. R28 was sitting in her wheelchair in the living room area and her left hand clenched and pulled up to her chest. R28 was not wearing a splint on her left hand. During observation on 11/30/22, at 6:56 a.m. nursing assist (NA)-E entered R28's to get R28 ready for the day. R28 was lying in bed with her left hand laying across her stomach and R28's left hand was clenched. R28's resting hand brace was on the table next to the bed. NA-E assisted R28 with her morning cares but did not apply the left-hand splint. TMA-A entered the room and obtained a blood sugar reading using her left hand and only moved the index finger about 1 inch from the clenched hand. When TMA-A completed the blood sugar she exited the room and did not put the left-hand splint on. During observation on 11/30/22, at 7:21 a.m. R28 was in the living room area watching TV and her left hand was clenched and pulled up to her chest. R28 was not wearing the left-hand splint. The left-hand splint remained on R28's table in	F 688	residents having the potential to be affected by the same deficient practice. All residents using medical devices have the potential to be affected. Director of Nursing and/or designee will audit all residents currently utilizing medical equipment to maintain mobility and ROM. Physicians' orders will be reviewed for compliance to ensure all medical devices have the proper orders. Care plans will be reviewed to ensure all residents utilizing an assistive device to maintain ROM/Mobility is care planned appropriately with detailed instruction on putting on and taking off device. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Director of Nursing and Supervisor of Therapy and Rehabilitation will hold an in-service educating nursing staff on performing ROM including usage and implementation of assistive devices. The education will detail the importance of following the therapy program. At weekly Medicare meetings all residents who are care planned for ROM will be reviewed for participation, program revisions and/or care plan updates. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing, Quality Specialist or designee, to conduct observation audits of 3 random residents care planned for ROM to ensure participation, revision and care plan	

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F 688	Continued From page 8 her room. During observation on 12/2/22, at 9:08 a.m. R28 was in the living room area watching TV and did not have the left-hand brace on. During an interview on 12/2/22, at 9:20 a.m. NA-E stated R28 should have always her brace, except for when eating. When R28 did not have the splint on regularly, R28's hand can become stiff and difficult to straighten out. R28 did not have the left-hand brace when NA-E arrived for her morning shift. NA-E stated she got R28 up and ready that morning and forgot to put on the left-hand brace and should have. During an interview on 12/2/22, at 9:30 a.m. the occupational therapist (OT) stated R28 was assessed and found had a lot of tension in her left hand and was started on a range of motion program. A left-hand splint was added because the range of motion program was not enough. R28 should wear the left-hand brace except for during meals and activities where she could use her hand. The OT stated she forgot to place the splint and after working with R28 that morning. During an interview on 12/2/22, at 10:13 a.m. the director of nursing stated R28 was supposed to wear a left-hand splint at all times except for meals. It was identified in the care plan and would expect staff to follow the care plan. The facility policy Restorative-Splinting dated 5/3/22, identified splinting care be beneficial way to prevent and treat contractures.	F 688	updates as needed. Daily x 2weeks, 3x/wk for 2 weeks, 1x/wk for 4 weeks then 1x month x 3 months until compliance is sustained. The results will be brought to the monthly QAPI meeting for review and/or further recommendations.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		1/17/23

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F 880	Continued From page 9 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 10 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure mechanical lifts were disinfected between resident for 2 of 5 residents (R9, R15) observed to be transferred with mechanical lift. . Findings include: R9's quarterly Minimum Data Set (MDS) dated 9/2/22, identified R9 had severe cognitive impairment with a diagnosis of Alzheimer's	F 880	F880 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R9 and R15 reside on Dove Island unit. During the Annual Survey, this item was identified with the RN Case manager as an item of concern. The RN Case Manager Immediately conducted staff education on her unit and placed	

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F 880	Continued From page 11 disease. R9 was totally dependent on staff for all activities of daily living and was unable to ambulate. R15's quarterly MDS dated 11/14/22, identified R15 had moderately impaired cognition with a diagnosis of dementia. R15 required staff assistance with bed mobility, transfers, toilet use and was unable to ambulate. On 11/30/22, at 6:48 a.m. nursing assistant (NA)-F and NA-G were observed using the total mechanical lift to transfer R9 from the bed to the wheelchair. Upon completion of the transfer, NA-G pushed the total mechanical lift out of R9's room and placed the lift up against the wall in the hallway. NA-F and NA-G were not observed to disinfect the lift after use and prior to leaving it in the hallway. During observation on 11/30/22, at 7:03 a.m. NA-G wheeled the same total mechanical lift into R15's room. NA-F and NA-G used the same lift to transfer R15 from the bed to the wheelchair. During interview on 11/30/22, at 7:19 a.m. NA-G stated she had not disinfected the total mechanical lift after transferring R9 and prior to transferring R15. NA-G stated the same total mechanical lift was used without being disinfiected between the two residents. During interview on 11/30/22, at 7:22 a.m. NA-F stated the total mechanical lift was not disincected after transferring R9 or prior to transferring R15. During interview on 11/30/22, at 7:23 a.m. licensed practical nurse (LPN)-A stated staff were	F 880	signage on the unit lifts to remind staff of the requirement to clean mechanical lift between each patient use. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents using the mechanical lift have the potential to be affected by this deficient practice. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Root Cause Analysis was conducted on 12/28/22 per the DPOC. Items for education with staff were identified through this process. Staff competencies were developed. Staff education and competency evaluation will be provided for all clinical staff who are trained to use the mechanical lift. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits of staff cleaning mechanical lift equipment will be conducted by DON or Quality Specialist Nurse or designee. Audits will be conducted on 3 random dependent residents daily X2 weeks, 3X/week for 2 weeks, 1X/week for 4 weeks then 1x per month for 3 months until compliance is sustained. The results will be brought to the monthly QAPI meeting for review and/or further recommendations.	

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F 880	Continued From page 12 to disinfect the mechanical lifts after each use and it was not appropriate to use the lift on more than one resident without cleaning in between uses. During interview on 11/30/22, at 7:48 a.m. registered nurse (RN)-B stated mechanical lifts were to be disinfected after every use and staff should not use the lift from one resident to another without disinfecting it between uses. Staff were aware of the expectation. During interview on 12/2/22, at 11:49 a.m. the director of nursing (DON) stated direct care equipment should be disinfected after each use to prevent the spread of potential infection. The facilities Safe Resident Handling Equipment Competency Validation Checklist, dated 11/21, directed staff to clean mechanical lifts after use.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 21, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: ZQNK11

Dear Administrator:

The above facility was surveyed on November 28, 2022 through December 2, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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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 11/2/22 through 12/2/22, a standard licensing survey was conducted completed 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 that you have reviewed these orders, and identify the	2 000		

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2 000	Continued From page 1 date when they will be completed. The following complaint H53186033C (MN87700) was found to be SUBSTANTIATED; however, no deficiencies were cited due to actions taken by the facility. The following complaints were found to be UNSUBSTANTIATED: H53185928C (MN87574) H5318043C (MN79875) H53185929C (MN85414) H53186026C (MN86687) H53186027C (MN86440) H53186028C (MN85379) H53186029C (MN85250) H53186030C (MN85252) H53186031C (MN85328) H53186032C (MN85788) 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	2 000		

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2 000	Continued From page 2 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please 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. 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		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to review for and/or complete a significant change in status assessment (SCSA) when two or more areas of change in resident	2 545	Corrected	1/17/23

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2 545	Continued From page 3 status were identified for 1 of 5 resident (R34) reviewed for activities of daily living. Findings include: R34's quarterly Minimum Data Set (MDS) dated 6/21/22, identified R34 had severe cognitive impairment and diagnoses included femur fracture with joint replacement surgery, cognitive communication deficiency and heart disease. R34 was independent with transfers and ambulation in the room and required supervision with bed mobility, grooming, dressing, toileting and ambulation in the corridor. During interview on 12/1/22, at 10:03 a.m. registered nurse (RN)-B stated in September of 2022, R34 had a fall that resulted in a fracture and R34 had significant decline in ADL's During interview on 12/2/22, at 11:04 a.m. the director of nursing (DON) stated staff complete a significant change MDS when a resident had two changes and the resident was not expected to recover from the changes. R34 had a fall with fracture in September 2022, and upon return from the hospital R34 started and completed physical therapy. The DON stated a significant change MDS should have been completed when R34 finished physical therapy as R34 never returned to baseline. The facilities MDS Resident Assessment Instrument (RAI) policy reviewed 6/6/22 identified a significant change assessment should be completed upon identification of the residents change. The Minimum Data Set 3.0 Manual V1.17.1 dated 10/19, identified assessment Management	2 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
2 545	Continued From page 4 Requirements and Tips for Significant Change in Status Assessments: A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident current status to the most recent comprehensive assessment and any subsequent quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks. Guidelines for Determining a Significant Change in Resident Status: The final decision what constitutes a significant change in status must be based upon the judgment of the IDT (interdisciplinary team). MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within two weeks. However, staff must note these transient changes in the resident status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required. Some Guidelines to Assist in Deciding If a Change is Significant or Not: Decline in two or more of the following: Any decline in an ADL physical functioning area where a resident is newly coded as extensive assistance, total dependence, or activity did not occur; Resident incontinence pattern changes or there was placement of an indwelling catheter. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures for comprehensive significant change assessments. Nursing staff could be educated as necessary to the importance of significant change comprehensive assessments. The DON or designee, could conduct audits on a regular basis to ensure compliance.	2 545		

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2 545	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 545		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to apply a hand splint for 1 of 3 residents (R28) reviewed for range of motion services. Findings include: R28's significant change Minimum Data Set (MDS) dated 11/28/22, identified severe cognitive impairment and was totally dependent on staff for her activities of daily living. R28 was identified to be on a restorative nursing program and utilized a splint.	2 890	Corrected	1/17/23

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2 890	Continued From page 6 R28's care plan dated 10/26/22, identified R28 required assistance with a left resting hand splint. R28 was to wear left resting hand splint all day besides mealtime and activities. R28's occupational therapy noted dated 10/28/22, identified R28 was tolerating splint used for left hand positioning and no further changes were required at this time. During observation on 11/29/22, at 8:16 a.m. R28 was sitting in her wheelchair in the living room area and her left hand clenched and pulled up to her chest. R28 was not wearing a splint on her left hand. During observation on 11/30/22, at 6:56 a.m. nursing assist (NA)-E entered R28's to get R28 ready for the day. R28 was lying in bed with her left hand laying across her stomach and R28's left hand was clenched. R28's resting hand brace was on the table next to the bed. NA-E assisted R28 with her morning cares but did not apply the left-hand splint. TMA-A entered the room and obtained a blood sugar reading using her left hand and only moved the index finger about 1 inch from the clenched hand. When TMA-A completed the blood sugar she exited the room and did not put the left-hand splint on. During observation on 11/30/22, at 7:21 a.m. R28 was in the living room area watching TV and her left hand was clenched and pulled up to her chest. R28 was not wearing the left-hand splint. The left-hand splint remained on R28's table in her room. During observation on 12/2/22, at 9:08 a.m. R28 was in the living room area watching TV and did	2 890		

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2 890	Continued From page 7 not have the left-hand brace on. During an interview on 12/2/22, at 9:20 a.m. NA-E stated R28 should have always her brace, except for when eating. When R28 did not have the splint on regularly, R28's hand can become stiff and difficult to straighten out. R28 did not have the left-hand brace when NA-E arrived for her morning shift. NA-E stated she got R28 up and ready that morning and forgot to put on the left-hand brace and should have. During an interview on 12/2/22, at 9:30 a.m. the occupational therapist (OT) stated R28 was assessed and found had a lot of tension in her left hand and was started on a range of motion program. A left-hand splint was added because the range of motion program was not enough. R28 should wear the left-hand brace except for during meals and activities where she could use her hand. The OT stated she forgot to place the splint and after working with R28 that morning. During an interview on 12/2/22, at 10:13 a.m. the director of nursing (DON) stated R28 was supposed to wear a left-hand splint at all times except for meals. It was identified in the care plan and would expect staff to follow the care plan. The facility policy Restorative-Splinting dated 5/3/22, identified splinting care be beneficial way to prevent and treat contractures. SUGGESTED METHOD OF CORRECTION: The DON or designee, could review/ revise or develop and policies and procedures related to the facility restorative program. The DON, or designee, could provide training for all nursing staff related to the policies and procedures to	2 890		

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2 890	Continued From page 8 esure they are implemented as assessed and care planned. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine grooming and personal hygiene to 1 of 5 residents (R4) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R4's quarterly Minimum Data Set (MDS) dated 11/15/22, identified R4 had severe cognitive impairment and was totally dependent on staff for personal hygiene and bathing. R4's care plan dated 10/10/22, identified R4 required total assistance with grooming, and incontinence care, with a goal that R4 would maintain ADL function with staff assistance.	2 920	Corrected	1/17/23

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2 920	Continued From page 9 On 11/30/22, at 6:45 a.m. R4's morning care was observed with nursing assistant (NA)-A and NA-B. NA-A removed bed sheet and checked R4's brief to see if it was wet or soiled. She stated R4's brief was dry and closed the brief. NA-A went to the closet to obtain R4's clothing. Both NA's assisted R4 to dress and placed the lift sheet underneath him. They transferred R4 into his chair using the mechanical lift. NA-A combed R4's hair and NA-B put on his shoes. NA-A turned R4's wheel chair in front of the television, secured his call light to his shirt and exited the room. The NA's did not provide any partial bed bath or peri care. When interviewed on 11/30/22, at 7:00 a.m. NA-A stated they did not do bed baths and only provided peri care when the resident was incontinent. They did not wash or dry resident with morning cares or provide any lotion to their skin. That was all done on the resident's bath day and it was not R4's bath day. During interview on 12/2/22, at 9:00 a.m. NA-C stated she assisted R4 to get up the morning of 12/2/22. NA-C assisted R4 with a partial bath, using a warm basin of warm soapy water. R4 liked the water slightly soapy with his morning partials and was fully cooperative with morning care. She washed and dried his torso, back and peri area and applied lotion to his back. She felt R4 enjoyed his morning partials and she could not think of a time he ever refused it or resisted it. When interviewed on 12/2/22, at 10:30 a.m. licensed practical nurse (LPN)-A stated the NA's typically assisted residents with a partial bath when getting them up for the day. A partial bath would include washing a residents back and peri	2 920		

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2 920	Continued From page 10 area and was done daily when getting the resident up for the day. It was done daily and not just on bath day. It would be a concern if the NA's were not assisting residents with a partial daily. During interview on 12/2/22, at 11:30 a.m. the director of nursing stated she expected all dependent residents to receive a partial bath when assisting them to get up for the day. She found some of the newer NA's needed to be reminded of this and she was planning on doing more training with them regarding the issue. The facility policy Activities of Daily Living reviewed 11/29/22, identified any resident who was unable to carry out activities of daily living would receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. ADLs are necessary tasks conducted in the the normal course of a resident's daily life and included general personal and daily hygiene and grooming. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure all activities of daily living are met. The DON or designee could educate all appropriate staff on the policies and procedures.The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		1/17/23

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21375	Continued From page 11 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure mechanical lifts were disinfected between resident for 2 of 5 residents (R9, R15) observed to be transferred with mechanical lift. . Findings include: R9's quarterly Minimum Data Set (MDS) dated 9/2/22, identified R9 had severe cognitive impairment with a diagnosis of Alzheimer's disease. R9 was totally dependent on staff for all activities of daily living and was unable to ambulate. R15's quarterly MDS dated 11/14/22, identified R15 had moderately impaired cognition with a diagnosis of dementia. R15 required staff assistance with bed mobility, transfers, toilet use and was unable to ambulate. On 11/30/22, at 6:48 a.m. nursing assistant (NA)-F and NA-G were observed using the total mechanical lift to transfer R9 from the bed to the wheelchair. Upon completion of the transfer, NA-G pushed the total mechanical lift out of R9's room and placed the lift up against the wall in the hallway. NA-F and NA-G were not observed to disinfect the lift after use and prior to leaving it in the hallway. During observation on 11/30/22, at 7:03 a.m.	21375	Corrected	

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21375	Continued From page 12 NA-G wheeled the same total mechanical lift into R15's room. NA-F and NA-G used the same lift to transfer R15 from the bed to the wheelchair. During interview on 11/30/22, at 7:19 a.m. NA-G stated she had not disinfected the total mechanical lift after transferring R9 and prior to transferring R15. NA-G stated the same total mechanical lift was used without being disinfiected between the two residents. During interview on 11/30/22, at 7:22 a.m. NA-F stated the total mechanical lift was not disincected after transferring R9 or prior to transferring R15. During interview on 11/30/22, at 7:23 a.m. licensed practical nurse (LPN)-A stated staff were to disinfect the mechanical lifts after each use and it was not appropriate to use the lift on more than one resident without cleaning in between uses. During interview on 11/30/22, at 7:48 a.m. registered nurse (RN)-B stated mechanical lifts were to be disinfected after every use and staff should not use the lift from one resident to another without disinfecting it between uses. Staff were aware of the expectation. During interview on 12/2/22, at 11:49 a.m. the director of nursing (DON) stated direct care equipment should be disinfected after each use to prevent the spread of potential infection. The facilities Safe Resident Handling Equipment Competency Validation Checklist, dated 11/21, directed staff to clean mechanical lifts after use. SUGGESTED METHOD FOR CORRECTION:	21375		

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21375	Continued From page 13 The DON and/or designee could review and/or develop policies and provide education for staff regarding disinfect equipment between resident use to prevent the spread of potential infections. The DON/ designee could audit staff to ensure equipment was disinfected according to policies and procedures. The audits could be brought to the QAPI committee for further review and recommendations on continued auditing or changes in the plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		

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	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**11/29/2022**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/29/2022. At the time of this survey, Good Samaritan Society-International Falls was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 01/03/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Good Samaritan Society International Falls is a new 1-story building, no basement, and was determined to be Type V (111) construction. The building is separated from the new assisted living building with a 2-hour fire barrier. The building is fully fire sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 edition) with quick response sprinkler heads. The facility is also protected by a complete automatic fire	K 000		

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K 000	Continued From page 2 alarm system with smoke detectors throughout the corridors and areas open to the corridor and in all sleeping rooms that is monitored that is installed in accordance with NFPA 72 "The National Fire Alarm Code" (2010 edition). The building is divided into 3 smoke compartments by 1-hour smoke barriers and 2-hour fire barriers. The facility has a capacity of 54 beds and had a census of 43 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.	K 324		1/17/23

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

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K 324	Continued From page 3 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 11/29/2022, between 10:30am and 1:30pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for semi-annual kitchen hood suppression system inspections for the last six (6) months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	K 324 □ Cooking Facilities hood suppression system completion 1. Detailed description of the corrective action taken or planned to correct the deficiency □ The facility is able to produce documentation to support the completion of the inspection of the kitchen hood ventilation and fire suppression system conducted on 8/23/2022 by LVC. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur □ The Maintenance Director will create a Life Safety Code (LSC) binder with all documents required for review during a Life Safety Code inspection to ensure all documents are prepared at the time of inspection. Each tab will indicate the frequency required for each task as a quick reference for any staff member to ensure completion. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained □ The Maintenance Director will bring the LSC binder to the monthly QAPI Committee meetings for committee review and assurance of completion. 4. Identify who is responsible for corrective actions and monitoring compliance - The Maintenance Director is responsible for development of the LSC	

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	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**11/29/2022**

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K 324	Continued From page 4	K 324	binder and for presenting completed Kitchen Hood Inspection Reports to the QAPI committee. 5. Actual or proposed date for completion of remedy - January 17th, 2023.	
K 355 SS=C	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/29/2022 between 10:30 am and 1:30 pm, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 355	K 355 □ Portable Fire Extinguishers 1. Detailed description of the corrective action taken or planned to correct the deficiency □ The facility is able to produce documentation to support the completion of Fire Extinguisher inspection of facility units as of August, 2022 completed by LVC. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur □ The facility has requested that the most recent and all future fire extinguisher inspections be documented by the contractor in a report provided the end of the inspection with the full name and credentials of the contractor conducting the inspection. These reports will be kept in the LSC binder for immediate reference upon entrance during Life Safety Code inspection. 3. Indicate how the facility plans to	1/17/23

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K 355	Continued From page 5	K 355	monitor future performance to ensure solutions are sustained - The Maintenance Director will bring the LSC binder to the monthly QAPI Committee meetings for committee review and assurance of completion. 4. Identify who is responsible for corrective actions and monitoring compliance - The Maintenance Director is responsible for development of the LSC binder and for presenting completed Fire Extinguisher Inspection Reports to the QAPI committee. 5. Actual or proposed date for completion of remedy - January 17th, 2023.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections	K 372	K 372 □ Smoke Barrier Penetration 1. Detailed description of the corrective action taken or planned to correct the	1/17/23

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K 372	Continued From page 6 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 11/29/2022 between 10:30 am and 1:30 pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to Dove Island, Voyager Haven and Compton Cottage. 2. On 11/29/2022 between 10:30 am and 1:30 pm, it was revealed by observation that there was a penetration in a rated fire wall in the house keeping closet in the Compton Cottage wing. An interview with Maintenance Director verified these deficient findings at the time of discovery	K 372	deficiency - Penetration running from one smoke compartment to another above the doors leading to each unit and the Kempton Cottage Housekeeping closet will be caulked with fire rated materials to maintain the integrity of the smoke compartment for each area. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur - Maintenance Director will implement an Above Ceiling Permitting requirement for any contractor who is working above the ceiling. This requirement will alert the contractor to identify and caulk any areas of smoke compartment penetration as part of their expectation for work completion. Any areas identified will be inspected by the Maintenance Director and the Contractor for mutual agreement that work is complete. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained □ The Maintenance Director will conduct a whole house audit of all facility smoke compartments to ensure all penetrations are identified and addressed. Maintenance Director will develop a log for all contractors who enter to work, if their work will include potential for above ceiling work, and if the Above Ceiling Permitting requirement will need to be implemented. The log will be reviewed by the QAPI committee at monthly meetings to identify any additional follow up. 4. Identify who is responsible for corrective actions and monitoring compliance - Maintenance Director is	

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K 372	Continued From page 7	K 372	responsible for presenting the whole house audit x 1 and the monthly contractor log to the QAPI committee on a monthly basis x 12 months. 5. Actual or proposed date for completion of remedy - January 17th, 2023.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/29/2022, between 10:30am and 11:30pm, it was revealed by a review of available documentation that the facility was unable to show completed fire drills in the first quarter	K 712	K 712 □ Fire Drills 1. Detailed description of the corrective action taken or planned to correct the deficiency □ The facility has identified that the record keeping of Fire Drill Completion will need to be maintained in a central location. Fire drill will be conducted for the Evening Shift as scheduled on the week of 1/3/23-1/6/23. The fire drill requirement and policy will be reviewed by the Maintenance Director or any designees that will conduct fire drills ongoing. 2. Address the measures that will be put	1/17/23

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K 712	Continued From page 8 (January - March), second quarter (April - June), third quarter (July - September) fourth quarter (October - December). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	in place to ensure the deficiency does not reoccur - The Maintenance Director will create a Life Safety Code (LSC) binder with all documents required for review during a Life Safety Code inspection to ensure all documents are prepared at the time of inspection. Each tab will indicate the frequency required for each task as a quick reference for any staff member to ensure completion. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained - The Maintenance Director will bring the LSC binder to the monthly QAPI Committee meetings for committee review and assurance of completion. 4. Identify who is responsible for corrective actions and monitoring compliance - The Maintenance Director will bring the LSC binder to the monthly QAPI Committee meetings for committee review of Fire Drill Reports and assurance of completion. 5. Actual or proposed date for completion of remedy - January 17th, 2023.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.	K 761		1/17/23

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K 761	Continued From page 9 Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/29/2022, between 10:30am and 1:30pm, it was revealed by a review of available documentation that Fire Door inspections where not completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	K 761 □ Maintenance Inspection and Testing Doors 1. Detailed description of the corrective action taken or planned to correct the deficiency □ The facility is able to produce documentation to support the completion of Fire Door Inspection most recently completed on 10/18/2022 by maintenance staff. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur - The Maintenance Director will create a Life Safety Code (LSC) binder with all documents required for review during a Life Safety Code inspection to ensure all documents are prepared at the time of inspection. Each tab will indicate the frequency required for each task as a quick reference for any staff member to ensure completion. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained - The Maintenance Director will bring the LSC binder to the monthly QAPI Committee meetings for committee review and assurance of completion. 4. Identify who is responsible for corrective actions and monitoring compliance - The Maintenance Director is	

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K 761	Continued From page 10	K 761	responsible for development of the LSC binder and for presenting the completed Fire Door Inspection logs to the QAPI committee. 5. Actual or proposed date for completion of remedy - January 17th, 2023.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/29/2022, 10:30am and 1:30pm, it was revealed during documentation review and an interview with the Maintenance Director that the utility risk assessment document could not be provided at the time of the survey.	K 901	K 901 □ Fundamentals □ 1. Detailed description of the corrective action taken or planned to correct the deficiency □ The facility was able to produce a copy of the annual Facility Utilities Risk Assessment completed on 12/17/21. The updated Facility Utilities Risk Assessment will be completed before 1/17/23. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur - The Maintenance Director will create a Life Safety Code (LSC) binder with all documents required for review during a Life Safety Code inspection to	1/17/23

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K 901	Continued From page 11 An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 901	ensure all documents are prepared at the time of inspection. Each tab will indicate the frequency required for each task as a quick reference for any staff member to ensure completion. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained - The Maintenance Director will bring the LSC binder to the monthly QAPI Committee meetings for committee review and assurance of completion. 4. Identify who is responsible for corrective actions and monitoring compliance - The Maintenance Director is responsible for development of the LSC binder and for presenting the Facilities Utility Risk Assessment to the QAPI committee. 5. Actual or proposed date for completion of remedy - January 17th, 2023.	