STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Pine River	518 Jefferson Avenue Pine River, MN 56474

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 40948 Based on observation, interview, and document review, the facility failed to ensure the required nurse staffing information was consistently posted on a daily basis and failed to identify when the posting changed due to call ins. This had potential to affect all 26 residents along with staff and visitors who could wish to review this information. Findings include: During observation on 2/2/25 at 12:20 p.m., the staff in a clear hard plastic sleeve on the nurses' desk upon entrance to the facility. The staff posting form identified the facility name, date, census, shift and total hours for licensed practical nurse (LPN). nursing assistant (NA), registered nurse (RN) case manager, and RN. The posting for 2/2/25, identified a census of 26 (that was corrected from 27). The 6:00 am to 6:00 pm shift identified one NA but did not identify the total hours (hr) worked, one RN case manager for 11.5 hrs which is less than the 12-hour shift identified on the posting. The 6:00 a.m. to 2:30 p.m. shift identified one LPN for 8 hrs, one NA but did not identify the total hours worked. The 2:15 p.m. to 10 45 p.m. shift identified two NA's for a total of 4.25 hours which was not reflected of the shift, two RN's with no total hours identified. The 6:00 p.m. to 6:00 a.m. shift identified one NA for 11.5 hrs and one RN for 11.5 hours both of which were not the full 12 hours identified for the shift. Further, the posting failed to identify the staff hours worked due to call-ins, vacations and/or staff shortages. The working schedule for 2/2/25, identified from 6:00 a.m. to 2:30 p. m. there was one LPN and one NA, from 6:00 a.m. to 6:00 p.m. there was one RN and one NA, from 2:15 p. m. to 10:45 p.m. there was one RN, one LPN, and one NA, from 6:00 p.m. to 6:00 a.m. there was one RN and one NA. During observation on 2/3/25 at 4:11 p.m., the staff posting for 2/3/25, identified the facility name, date, census, shift and total hours for director of nursing (DON), health information management technician (HIM), LPN. NA, RN case manager, and supervisor ancillary services. The posting identified a census of 25 (corrected from 26.) The 6:00 am to 2:30 p.m. shift identified one LPN for a for 8 hrs, one NA without identifying the total hours worked. The 2:15 p.m. to 10:45 p.m. identified two NA's with a total of 4.25 hrs and two RN's without identifying the total hours worked. The 6:00p.m. to 6:00a.m. identified one NA for 11.5 hrs and one RN for 11.5 hours, the total hours worked did not match the shift. Further, the posting failed to identify the staff hours worked due to call-ins, vacations and/or staff shortages. The working schedule for 2/3/25, identified from 6:00 a.m. to 2:30 p.m. there was one LPN, one RN and two NAs, from 2:15 p.m. to 10:45 p.m. there were two LPNs and two NAs, from 10:30 p.m. to 7:00 a.m. there was one LPN and one NA. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	During observation on 2/4/25 at 11:13 a.m., the staff posting for 2/4/25, identified the facility name, date, census, shift and total hours for DON, HIM, LPN. NA, RN case manager, and supervisor ancillary services. The posting identified a census of 25 (corrected from 27). The 6:00 am to 2:30 p.m. shift identified one LPN for a for 8 hrs, two NA for a total of 16 hrs and one RN without identifying the total hours worked. The 8:00 a. m. to 4:30 p.m. shift identified the DON worked for 8hrs along with) RN case managers for a total of 8 hrs. The 2:15 p.m. to 10:45 p.m. shift Identified one LPN for 8 hrs with a handwritten notation in the box 1 RN + without further information and two NA's for a total of 8 hrs. The 10:30 p.m. to 7:00 a.m. shift identified in the LPN box a zero with a line crossed through with a hand notations 1 RN without further information and one NA for a total of 4 hrs but did not identify what the shift worked for those 4 hrs. Further, the posting failed to identify the staff hours worked due to call-ins, vacations and/or staff shortages. The working schedule for 2/4/25, identified from 6:00 a.m. to 2:30 p.m. there was one LPN, one RN and two NA's from 2:15 p.m. to 10:45 p.m. there were two LPNs and two NAs, from 10:30 p.m. to 7:00 a.m. there was one LPN [10:30 p.m. to 3:00 a.m.] and one RN [from 3:00 a.m. to 7:30 a.m.] and one NA. During an interview on 2/4/25 at 12:07 p.m., the DON stated it was the staffing coordinator's responsibility to ensure the posting was available and updated as needed. DON stated when the staff coordinator was out it was her responsibility to ensure it was printed out of OnShift (a staff program for computer) and posted Once the posting was posted it should be updated as changes occur. On 2/2/25, the DON was working and stated she was responsible for the posting and did not update it with changes or call-ins, as she just did not have time. During an interview on 2/4/25 at 1:18 p.m., the staffing coordinator stated it was her responsibility to ensure the daily staff posting was done. If she was going to be gone or for the weekends, she made sure all the current information is in OnShift and print them off to be posted on the correct days. Some of the postings looked different as when they were printed from OnShift, sometimes the RN column was missing. The staffing coordinator did not know how to get it to show up. When the staffing daily posted, she always checks to ensure the census is updated on the form; however, if there were call ins or schedule changes, she did not update the staff posting during the day. The staffing coordinator was not aware the staff posting would need to be update and reflect the correct shift and hours The facility was always filling empty shift through the day. During an interview on 2/5/25, at 11:04 a.m., the administrator stated it was the expectation the daily staff posting would be accurate. The facility's Nurse Staff Daily Posting Requirements dated 12/2/24, identified it is important to keep the report updated by making staffing changes as they occur.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 42075 Based on observation, interview, and document review the facility failed to ensure dietary staff were educated on the required dishwasher tempuratures for 4 of 5 staff (cook (CK)-A, dietary aide (DA)-A, DA-B, DA-C, dietary manager (DM) who used the dishwasher. This had the potential to affect all 26 residents who consumed foods from the kitchen. Findings include: On 2/2/25 at 11:31 a.m., an initial kitchen tour was completed with dietary aide (DA)-A. A single commercial dishwasher was observed along the wall. Two gauges were located on the top front of the dishwasher. One gauge was labeled wash, and the other was labeled rinse. DA-A stated she would run dishes through a cycle, then monitor and document the highest temperatures of the wash and rinse cycles. Staff documented the temperatures three times daily on the temperature log. DA-A stated the wash temperature was okay and reached a minimum of 160 degrees, but the minimum rinse temperature was supposed to be 180 degrees and the tempurare had been running low, ranging 173-178, since January 2025. DA-A stated she was unaware what the numbers meant and had not been given direction on what to do other than to document the numbers. The Dish Machine Temperature Log(s) were reviewed and identified the following: - January 1, 2025, through February 2, 2025, the dishwasher rinse temperature was recorded between 164 degrees and 176 degrees and reached the minimum of 180 degrees 4 times during the date range. - December 2024, identified 72 of 93 recorded dishwasher rinse temperatures were below 180 degrees when monitored for the three meals. - November 2024, identified 66 of 90 recorded dishwasher rinse temperatures were recorded below 180 degrees when monitored for the three meals. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/2/25 at 12:20 p.m., the dietary manager, (DM) stated during January 2025, the dishwasher had not been reaching the minimum rinse temperature and on 1/19/25, the repair man was contacted, and the thermostat was replaced. The dish machine was a hot water single machine and had a rinse brick for the sanitizer. Hot water flushed through a rinse brick and dissolved the appropriate amount of rinse needed to sanitize the dishes. DM stated the dishes were getting sanitized because the brick was getting smaller, and the dishes were hot when they came out. DM stated she had not rechecked the rinse temperature or the log after the repair man left, and thought the machine was functioning properly. DM stated she checked the rinse temperature on 1/31/25, and the temperature was above 180 degrees. DM informed the staff to continue checking the temperatures and if the rinse cycle went below 177 degrees to use the three-compartment sink process. DA stated she had not documented the observations or the discussions she had with the dietary staff. The DM was unable to identify the rinse cycle was supposed to reach a tempurature of 180 degrees F on the rinse cycle. The DM stated she was unaware how low the temperatures had gotten when she reviewed the tempurature logs. DM reviewed the February temperature log which indicated the final rinse temperatures of 172 through 174. DM stated she informed her staff to monitor the rinse temperatures and if the temps were below 177 degrees, then use the three compartment sinks. On 2/4/25 at 12:16 p.m., DA-C stated her primary job was washing dishes. The final rinse temperature was checked three times daily, once at each meal. DA-C stated she ran dishes through the wash machine, monitored the gauges and documented the highest temperature reached during the wash and rinse cycles. DA-C stated she was uncertain if they used the three compartment sinks during the month of January because the tile was ripped up over by the sink and could not remember if they used the sinks during that time. - DA-B approached the conversation and stated she washed the dishes one evening shift per week and documented the highest wash and rinse temperature during the cycle. DA-B stated she had not been given direction of what to do if the rinse temperatures were below 180 degrees and had not known when they would use the three sinks unless the dishwasher was broken. On 2/4/25 at 1:34 p.m., the administrator stated she took the Basics of Food Safety in Long Term Care Facilities online training that the staff were required to take. The administrator stated the training did not specifically identify what temperature's the dishwasher needs to reach; however, the log does identify the minimum temperatures for rinsing. On 2/5/25 at 8:54 a.m., DM stated she was not aware of the facility Warewashing-Mechanical and Manual-Food and Nutrition policy or the Mechanical Ware Washing Food and Nutritional Competency Checklist included in the policy. DM stated the staff completed the Basics of Food Safety in Long Term Care Facilities online coarse although the course did not include information regarding the importance of appropriate wash and rinse temperatures for the dishwasher. DM stated competency checklists for all dietary staff were not completed. The undated ECOLab Dishmachine ES-2000HT manufacturer's instructions identified the sanitizing rinse water minimum temperature of 180 degrees. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility Warewashing-Mechanical and Manual - Food and Nutrition policy reviewed 3/25/24, identified warewashing as the means to clean and sanitize utensils and food-contact surfaces of equipment. The policy identified food and nutrition employees were to ensure food preparation equipment, dishes and utensils were effectively cleaned, sanitized to destroy potential disease carrying organisms, and stored in a protective manner. The policy identified staff were to follow manufacturers instructions for the specific dishwasher model for minimum temperatures for safe sanitization of dishes as well as complete the Food and Nutrition Competency Checklist for mechanical warewashing.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42075 Based on observation, interview, and document review the facility failed to ensure the dishwasher rinse cycle reached or exceeded a tempurature to effectively sanitize dishes.This had the potential to affect 26 residents that consumed food from the kitchen. Findings include: On 2/2/25 at 11:31 a.m., an initial kitchen tour was completed with dietary aide (DA)-A. A single commercial dishwasher was observed along the wall. Two gauges were located on the top front of the dishwasher. One gauge was labeled wash, and the other was labeled rinse. DA-A stated she would run dishes through a cycle, then monitor and document the highest temperatures of the wash and rinse cycles. Staff documented the temperatures three times daily on the temperature log. DA-A stated the wash temperature was okay and reached a minimum of 160 degrees, but the minimum rinse temperature was supposed to be 180 degrees and the tempurare had been running low, ranging 173-178, since January 2025. DA-A stated she was unaware what the numbers meant and had not been given direction on what to do other than to document the numbers. The Dish Machine Temperature Log(s) were reviewed and identified the following: - January 1, 2025, through February 2, 2025, the dishwasher rinse temperature was recorded between 164 degrees and 176 degrees and reached the minimum of 180 degrees 4 times during the date range. - December 2024, identified 72 of 93 recorded dishwasher rinse temperatures were below 180 degrees when monitored for the three meals. - November 2024, identified 66 of 90 recorded dishwasher rinse temperatures were recorded below 180 degrees when monitored for the three meals. On 2/2/25 at 12:20 p.m., the dietary manager, (DM) stated during January 2025, the dishwasher had not been reaching the minimum rinse temperature and on 1/19/25, the repair man was contacted, and the thermostat was replaced. The dish machine was a hot water single machine and had a rinse brick for the sanitizer. Hot water flushed through a rinse brick and dissolved the appropriate amount of rinse needed to sanitize the dishes. DM stated the dishes were getting sanitized because the brick was getting smaller, and the dishes were hot when they came out. DM stated she had not rechecked the rinse temperature or the log after the repair man left, and thought the machine was functioning properly. DM stated she checked the rinse temperature on 1/31/25, and the temperature was above 180 degrees. DM informed the staff to continue checking the temperatures and if the rinse cycle went below 177 degrees to use the three-compartment sink process. DA stated she had not documented the observations or the discussions she had with the dietary staff. The DM was unable to identify the rinse cycle was supposed to reach a tempurature of 180 degrees F on the rinse cycle. The DM stated she was unaware how low the temperatures had gotten when she reviewed the tempurature logs. DM reviewed the February temperature log which indicated the final rinse temperatures of 172 through 174. DM stated she informed her staff to monitor the rinse temperatures and if the temps were below 177 degrees, then use the three compartment sinks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The infection control logs were reviewed from November through February and did not identfiy and gastrointestinal illness' and or outbreaks. Review of the service call summary forms identified the following: - 12/12/24: Regular Service Call - Rinse temperature of 178 degrees. - 1/13/25: Regular Service Call - Replaced temperature gauges that were not functioning properly. Rinse temperature before and after replacement at 180 degrees. - 2/3/25 Extra Service Request - Machine not hitting rinse temperature. Comments: Fixed stuck thermostat. A joint interview was completed with cook (CK)-A, DA-C and DA-B on 2/4/25 at 12:16 p.m CK-A stated she did not wash the dishes and prior to today was uncertain what the minimum rinse temperature should be. DA-C stated her primary role was washing dishes. DA-C stated she checked and documented the wash and rinse temperatures once per meal. DA-C stated she thought they had used the three compartment sink previously when the dish machine wasn't reaching minimum temperature. DA-C unable to remember the last time they used the three compartment sinks but thought it may have been in January 2025. DA-B stated she washed dishes one evening per week and checked the wash and rinse temperatures once during that meal. DA-B stated she wouldn't know what to do other than use the dishwasher, had not been directed to do anything differently and didn't know when they would use the three-compartment sinks. On 2/5/25 at 9:02 a.m., the maintenance/ ancillary services supervisor (MAINT) stated on 1/13/25, the dishwasher was not getting up to temperature. The repair mas was contacted and replaced the gauges. After that the dish machine was reaching temperature. Then on 2/2/25, DM reported the dish machine was not reaching temperature and contacted the repair man again. They came out on 2/3/25 and said the thermostat was stuck, they fixed it, and the dishwash machine had been reaching temperature since. The facility Warewashing-Mechanical and Manual - Food and Nutrition policy reviewed 3/25/24, identified warewashing as the means to clean and sanitize utensils and food-contact surfaces of equipment. The policy identified food and nutrition employees were to ensure food preparation equipment, dishes and utensils were effectively cleaned, sanitized to destroy potential disease carrying organisms, and stored in a protective manner. The policy identified staff were to follow manufacturers instructions for the specific dishwasher model for minimum temperatures for safe sanitization of dishes as well as complete the Food and Nutrition Competency Checklist for mechanical warewashing.