STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Stillwater	1119 Owens Street North Stillwater, MN 55082

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview and record review the facility failed to ensure facial hair was removed for 1 of 1 residents (R6) reviewed for dignity. R6's quarterly Minimum Data Set (MDS) dated [DATE], indicated R6 had cognitive impairment and diagnoses of multiple sclerosis and dementia. R6 had no refusals of care and required supervision for personal hygiene (combing hair, shaving, washing/drying face). R6's Kardex as of 4/16/24, indicated R6 required assist of one for bathing and personal hygiene of washing face and upper body. R6's Kardex lacked indication of any cares or preferences for chin hairs. R6's care plan revised on 6/21/23, indicated R6 had impaired assistance of daily living (ADL) performance related to multiple sclerosis and impaired mobility. R6 required assistance with personal hygiene and to encourage to wash face and upper body. R6's care plan lacked indication of preference of chin hairs or assistance for removal or shaving. An observation on 4/15/24 at 2:25 p.m., R6 was sitting in a wheelchair in their room. R6 had several white and gray hairs on her chin. R6 rubbed at them and stated yes they bother me- how do I get rid of them? An observation on 4/16/24 at 9:00 a.m., R6 was observed in the dining room finishing up breakfast. R6's chin hairs were present. When interviewed on 4/16/24 at 2:26 p.m., nursing assistant (NA)-C stated when residents had shower day, the shower, hair wash, nails and bed linens were changed. NA-C further stated a shave was completed if the resident wanted one, but an electric razor was needed and not all residents had an electric razor. If residents refused cares the nurse had to be notified and any refusals. NA-C verified R6 had chin hairs and was not aware of any requests to shave and did not know if the hair bothered R6. NA-C a shower on 4/15/24 and did not know if R6 had an electric razor for use. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 4/16/24 at 3:36 p.m. licenced pratical nurse (LPN)-C stated nursing assistants will let them know of any refusals of showers or shaves. If cares are refused, would need to check the care plan or Kardex on what cares were wanted and talk to the resident. If anything was refused or missed, it was passed on to the next shift. LPN-C did not recall if R6 had requested to be shaved or asked if the hair was bothersome. LPN-C further stated if wanted them removed, family would need to bring in an electric razor as there are not razors available for use. When interviewed on 4/22/24 at 2:08 p.m., the Director of Nursing (DON) expected staff to be asking about chin hairs or offering to shave them on bath days or anytime to ensure the resident was comfortable. DON further stated some residents have razors, but the facility has some available if needed. A facility policy titled Resident Dignity revised 11/16/23, directed staff to promote, support and maintain dignity for all residents. The policy directed staff to maintain dignity by grooming (hair, beards shaved, and nail) how the resident wished.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on interview and document review, the facility failed to ensure a baseline careplan had been completed for 2 of 2 residents (R89, R189) reviewed for baseline care plans. Findings include: R89's medical record indicated she was admitted to the facility on [DATE] and had diagnoses of fracture of lower end of right humerus, pain in right arm, and congestive heart failure (CHF). R89's medical record lacked a baseline care plan. During interview on 4/18/24 at 11:32 a.m., licensed practical nurse (LPN)-C stated when there was a new admission the receiving nurse was responsible for completing the nursing admission/readmission assessment ([NAME]) and that assessment would trigger the baseline care plan. LPN-A further stated I don't know what happens after that regarding the comprehensive care plan, adding interventions, and who was responsible for completing it. During interview on 4/18/24 at 11:49 a.m. LPN-B stated when there was a new admission the receiving nurse was responsible for completing the [NAME] and that assessment would trigger the baseline care plan. Then any nurse can add interventions to make it more comprehensive. During interview on 4/18/24 at 1:45 p.m, the nurse manager registered nurse (RN)-B stated the Minimum Data Set (MDS) nurse or the director of nursing (DON) were responsible for initiating the baseline careplan. The nurse receiving the new admit can also complete the [NAME] and that will trigger the baseline careplan. After, the nurses were responsible for letting the MDS nurse or herself know if something should be added to the care plan to make it more comprehensive but everyone is qualified. RN-B also stated baseline care plans should include things like how a resident transfers, mobility, activities of daily living (ADL), special treatments, if they have a catheter, etc. and verified R89 did not have one. RN-B stated careplans were important for the safety of the residents and so staff know how to care for them. During interview on 4/19/24 at 8:38 a.m. the MDS nurse stated when there was a new admission, she was responsible for creating the baseline careplan and this was done by talking to the resident, talking to therapy, and completing an assessment. The receiving nurse usually completes the [NAME] but anybody can put in an intervention. The MDS nurse verified R89 did not have a baseline care plan and wasn't sure why it was missed. 43007 R189 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R189's admission MDS dated [DATE], indicated R189 was admitted to the facility on [DATE], at risk for falls and had a fall with injury prior to admission. Further indicated, diagnosis of open reduction internal fixation (ORIF) of the left femur. R189's fall CAA dated 9/2/23, indicated R189 was at risk for falls related to being unable to ambulate without staff assistance due to unsteadiness, fall history within the last month prior to admission, and a fall after admission. R189's activity of daily living (ADL) functional/Rehabilitation potential CAA dated 9/2/23, indicated R189 required assistance with ADL's due to unsteadiness, weakness, and a fall prior to admission. R189's care plan dated 8/30/23, lacked any evidence of a fall care plan, fall history or any interventions to decrease the risk for falls. Further, indicated R189 had an ADL self care performance deficit related to [specify]. The care plan lacked any evidence of what R189's ADL self care performance deficit was related to and had no interventions. R189's kardex dated 8/30/23, lacked any evidence of R189's fall risk status or interventions to prevent falls. Further, lacked evidence on how to assist R189 during transfers or ambulation. During interview on 4/22/24 at 1:58 p.m., the director of nursing (DON) stated when their is a new admission the facility had 48 hours to complete a baseline careplan and the MDS or receiving nurse were responsible for initiating it. It can also be triggered from the [NAME]. The DON further stated the MDS nurse was responsible for adding interventions to make it more comprehensive but anyone can add them. She would expect the care plans to be individualized and it's important so staff can provide the right care for the residents and know how to take care of them. The facility's policy on baseline careplans dated 11/1/23, indicated each resident will have an individualized, person-centered, comprehensive plan of care that will include mesureable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on interview and document review the facility failed to comprehensively assess 1 of 1 resident (R13) reviewed for demetia care and 1 of 1 resident (R3) reviewed for accidents. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition, and diagnosis of dementia. It further indicated R13 was dependent on staff for activities of daily living (ADL) and mobility. R13's care plan dated 3/28/24, lacked any indication R13 had dementia. During interview on 4/18/24 at 11:32 a.m., licensed practical nurse (LPN)- C stated when there was a new admission the receiving nurse was responsible for completing the nursing admission/readmission assessment ([NAME]) and that assessment would trigger the baseline care plan. LPN-A further stated I don't know what happens after that regarding the comprehenisive careplan, adding interventions, and who was responsible for completing it. During interview on 4/18/24 at 11:49 a.m. LPN-B stated when there was a new admission the receiving nurse was responsible for completing the [NAME] and that assessment would trigger the baseline care plan. Then any nurse can add interventions to make it more comprehensive. During interview on 4/18/24 at 1:45 p.m, the nurse manager registered nurse (RN)-B stated the MDS nurse or the director of nursing (DON) were responsible for initiating the baseline careplan. The nurse receiving the new admit can also complete the [NAME] and that would trigger the baseline careplan. After that the nurses will let the MDS nurse or herself know if something should be added to the care plan to make it more comprehensive but everyone is qualified. RN-B further indicated if a resident had a diagnoses of dementia it should be included in their comprehensive careplan and careplans were important for the safety of the resident and so staff know how to care for them. During interview on 4/19/24 at 8:38 a.m., the MDS nurse stated when there was a new admission, she was responsible for creating the baseline careplan and this was done by talking to the resident, talking to therapy, and completing an assessment. The receiving nurse usually completes the [NAME] but anybody can put in an intervention. The MDS nurse stated if a resident had a diagnosis of dementia it should be addressed in their careplan and verified R13's comprehensive care plan didn't address it. During interview on 4/22/24 at 1:58 p.m., the director of nursing (DON) stated when their is a new admission the facility had 48 hours to complete a baseline careplan and the MDS or receiving nurse were responsible for initiating it. It can also be triggered from the [NAME]. The DON further stated the MDS nurse was responsible for adding interventions to make it more comprehensive but anyone can add them. She would expect the care plans to be individualized and it's important so staff can provide the right care for the residents and know how to take care of them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy regarding comprehensive care plans dated 12/4/23, indicated the care plan was driven by identified resident issues/conditions and their unique characteristics, strengths, and needs. When implemented in accordance with standards of good clinical practice, the care plan becomes a powerful practice tool representing the best approach to quality of care and quality of life. 44647 R3's quarterly MDS dated [DATE], indicated R3 was cognitively impaired and had diagnoses of chronic lung disease, kidney disease and weakness. R3's medical record lacked evidence an assessment had been completed to ensure safe use of the Kureg coffee maker. R3's care plan lacked evidence of use or assistance needed to ensure safe use of Kureg coffee maker. R3's assessment for use of Kureg coffee maker was requested however was not received. An observation on 4/16/24 at 1:49 p.m., R3 was sitting in the recliner watching television. R3 had a Kureg sitting on a side table next to their recliner. There was a small basket of coffee pods sitting in a basket next to it and a pink cup sitting under the spout. R3 stated family brings in the coffee pods and staff help fill the water revisor. R3 stated she made her own coffee when she wanted. When interviewed on 4/18/24 at 7:44 a.m., NA- A verified R3 had a Kureg coffee maker in their room. NA-A stated staff make sure it was filled with water and have it set up next to the recliner where she likes to watch television. NA-A wasn't sure if there were any safety concerns with R3 having it in place. When interviewed on 4/18/24 at 11:00 a.m., LPN-B stated they were not sure why R3 had a Kureg coffee maker and that was not normally something residents had in the facility. LPN-B further stated it could cause a safety concern with it being hot liquids, and some sort of assessment would be needed to make sure it was safe to use. When interviewed on 4/22/24 at 2:08 p.m., DON stated she wasn't sure how long R3 had been using the coffee maker as normally residents do not have appliances in their room. DON stated they expected some sort of assessment to be completed and it to be included in R3's care plan. DON further stated this was important to ensure safe use. An accidents policy related to appliance use was requested however was not available.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on observation, interview, and document review the facility failed to ensure nail care was completed for 1 of 1 resident (R19) dependent on staff for nail care. Findings include: R19's annual Minimum Data Set (MDS) dated [DATE], indicated R19 had moderately impaired cognition, diagnosis of traumatic brain injury (TBI), rejection of cares 1-3 times per week, and was dependent on staff for personal hygiene. R19's care plan dated 3/31/24, indicated R19 had an activities of daily living (ADL) self care performance deficit related to bradycardia evidenced by activity intolerance and required extensive assist of 1 with personal hygiene. R19's medical record lacked any documentation that nail care had been completed (nails had been cut). During observation and interview on 4/15/24 at 1:57 p.m., R19's nails were observed to be approximately 1/2 inch long with brown matter and chipped and jagged on his right hand. R19 stated he would like his fingernails to be cut short and he didn't like how long they were. During observation and interview on 4/16/24 at 1:18 p.m., R19 was sitting in his room in his wheelchair and stated his fingernails haden't been cut. R19's nails were observed to be approximately 1/2 inch long with brown matter and chipped and jagged on his right hand. During observation and interview on 4/17/24 at 12:38 p.m., R19 was sitting on his bed eating lunch at his bedside table and his nails were observed to be approximately 1/2 inch long with brown matter and chipped and jagged on his right hand. R19 stated his nails were still long, hadn't been cut and would like them to be. During interview on 4/18/24 at 9:00 a.m., nursing assistant (NA)-B stated nurses were responsible for cutting the residents nails even if they are not diabetic. During interview on 4/18/24 at 9:12 a.m., licensed practical nurse (LPN)-C stated NA's were responsible for cutting the residents nails, but wasn't sure who was responsible for cutting them if the resident was diabetic. LPN-C verified R19's nails were long and should've been cut. During interview on 4/18/24 at 1:45 p.m., the nurse manager registered nurse (RN)-B stated the NA's were responsible for trimming the residents nails, unless they are diabetic then it's the nurses responsibility. RN-B further indicated staff should let her or the MDS nurse know if a resident refused nail care and if the resident refused a lot then it would be added to the care plan. RN-B verified R19's nails were very long and she had cleaned and trimmed his nails after hearing the surveyor had asked about them. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/22/24 at 1:58 p.m., the director of nursing (DON) stated nurses and NA's were responsible for cutting residents nails. If the resident was diabetic it was preferable for a nurse to cut them but a NA could do it. She further stated the residents should have their nails cut once a week on bath day and if the resident refused it should be documented in their medical record. The facility's policy regarding ADL's dated 11/29/22, indicated the facility will provide residents with appropriate treatmemt and services to maintain or improve abilities in activities of daily living for the well being of mind, body, and soul.

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	245207	A. Building B. Wing	04/23/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview, and record review the facility to ensure weekly skin assessment was completed for 1 of 1 resident (R24) who had fall and sustained bruising and lacerations. Findings include: R24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R24 was cognitively intact and had diagnoses of congestive heart failure, atrial fibrillation, vascular disease, and weakness. Furthermore R24's MDS indicated R24 had a vascular wound and a skin tear. R24's care plan revised on 4/9/24, indicated R24 had actual impairment to skin integrity related to venous stasis ulcers to lower legs and required monitoring location, size, and treatment. Furthermore, R24 required weekly skin observations by licensed nurse. R24 had an actual fall with serious injury and required monitor/document/report as needed for 72 hours to health care provider any signs or symptoms of pain or bruising. R24's care plan lacked indication of any continued monitoring of R24's bruising and facial lacerations after 72 hours. R24's Kardex directed nursing assistant (NA) staff to notify nurse immediately of any new areas of skin breakdown noted during baths or daily cares. R24's nursing assistant task documentation dated 3/15/24-4/15/24, lacked indication R24 had skin monitoring completed on bath days. R24's medical record lacked indication a weekly skin assessment was completed by a licensed nurse since 1/2024. R24's nursing and provider orders reviewed on 4/16/24, indicated R24 required warfarin (anticoagulant medication to thin the blood and prevent clotting) 3 milligrams (mg) on Mondays and 4mg daily Tuesday-Sunday. R24's nursing and provider orders lacked indication of monitoring of left knee or left forehead injury sustained from R24's fall on 3/27/24. A review of R24's nursing progress notes showed the following: -on 3/27/24 at 7:20 p.m., R24 had a grape sized bump on left side of forehead, bleeding on face between lip and swelling/bruising on left knee, and a large skin tear to right deltoid. -on 3/27/24 at 10:44 p.m., R24 was noted to have bruise on forehead, bruise/skin tear on right arm. Continue to monitor. -on 3/28/24 at 2:34 p.m. R24 had increased bruising on left face related to fall and dressings were changed to right arm skin tear. (continued on next page)

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	245207	A. Building B. Wing	04/23/2024

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-on 4/2/24 at 7:53 a.m., R24 complained of increased pain to left knee and leg. R24 was noted to have large bruise from above knee to mid-calf. Leg appeared more swollen. Message left for NP. R24's medical record lacked indication of further assessment or monitoring of R24's facial and left leg bruising. An observation on 4/18/24 at 2:00 p.m., R24 was laying in bed. R24 had a dark scabbed area on the left forehead and a dark purple colored bruise on the left knee. R24 stated she had rolled out of bed a few weeks back and still had bruising. R24 further stated it was taking a long time for the bruising to go away because of the warfarin, but thought it was better. When interviewed on 4/18/24 at 8:28 a.m. licensed practical nurse (LPN)-B stated nurses complete the skin checks on bath days. If there was anything abnormal, then the provider would be notified for cares and monitoring. Usually, a weekly skin assessment would trigger for nurses in the electronic medical record during bath days but wasn't sure the process at this facility. LPN-B further stated if there were skin issues noted, the provider would be notified for treatment or monitoring orders. With any skin alteration an assessment would be needed and then continued weekly until improved. When interviewed on 4/18/24 at 2:18 p.m., nursing assistant (NA)-A was aware of R24's fall. NA-A further stated R24 was sent to the hospital and the following day had stitches under her nose, and a lot of bruising. NA-A stated nursing assistants monitored skin during the baths. NA-A further stated if anything was seen, the nurse would be notified. NA-A stated the bruising was known by the nurses. Some nurses will look at the skin themselves, but not all of them. NA-A further stated they do not document anything with the skin monitoring, just know it was done on bath day and the nurse completes documentation. When interviewed on 4/18/24 at 2:31 p.m. LPN-C stated when R24 rolled out of bed, she had open cuts to her face and was bleeding a lot due to taking an anticoagulant. When interviewed on 4/22/24 at 2:08 p.m., the Director of Nursing (DON) stated resident skin was monitored by all staff daily with cares. On bath days, NA's competed skin monitoring task and were expected to document in the tasks. If NAs found any skin concerns, redness, bruising, open areas, etc, they would report to the nurse. The nurse then would assess the area, document, and notify the provider. DON expected R24 to have weekly monitoring for her bruising and skin lacerations that occurred after their fall. This could be in a progress note or a weekly assessment. Monitoring skin with cares were important to catch any changes or complications. A facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation revised 4/26/23, directed staff to monitor any bruise, contusion, or skin tear weekly and any changes and/or progress toward healing should be documented on the skin observation assessment and on the resident care plan.

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	245207	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview, and record review the facility failed to ensure weekly skin assessments were completed for 1 of 1 residents (R8) reviewed for pressure injury. Findings include: R8's quarterly MDS assessment dated [DATE], indicated R8 was cognitively intact and had diagnoses of chronic lung disease, heart disease and pain. R8's MDS further indicated R8 required oxygen, had no current pressure injury but was at risk of developing skin injury. R8's skin Care Area Assessment (CAA) dated 12/3/23, indicated R8 was at risk of pressure injuries due to recent weight loss, terminal illness and devise use that may cause pressure (oxygen). R8's Kardex as of 4/18/24, indicated R8 had oxygen therapy and directed staff to notify nurse of any new skin breakdown, redness, blisters or bruising during bath and daily cares. R8's care plan revised 3/6/24, indicated R8 had potential for pressure ulcer development due to decreased mobility. Interventions included to education resident/family on causes of skin breakdown, importance of good nutrition and positioning. Interventions further included notification for any new areas of skin breakdown redness or blisters noted during bath days or in daily care. R8's care plan lacked indication weekly assessment of R8's skin was required on a weekly basis. A review of R8's active nursing and provider orders on 4/16/24, lacked indication R8 required routine skin assessments from nursing. R8's NA task for skin check on bath day dated 3/19/24-4/15/24, indicated the skin check was completed on 3/20/24. R8's medical record lacked a skin check was completed on a weekly or routine basis. An observation on 4/15/24 at 1:00 p.m., R8 was in bed. R8 was receiving oxygen via a nasal cannula. R8 stated there was some pain and irritation right below their nose the oxygen tubing. There was a small, reddened area just below R8's nose. R8 stated staff were aware but was not sure if anything was being done about it to prevent it. When interviewed on 4/17/24, at 1:18 p.m., R8 was sitting in their room. R8 stated there was no longer any pain or irritation from the oxygen. R8 no longer had a red area. When interviewed on 4/18/24 at 7:30 a.m., nursing assistant (NA)-A was not aware of any skin issues with R8's oxygen. NA-A stated nursing assistants monitored skin during the baths. NA-A further stated if anything was seen, the nurse would be notified. Some nurses will look at the skin themselves, but not all of them. NA-A further stated they do not document anything with the skin monitoring, just know it was done on bath day and the nurse completes documentation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. Building B. Wing	04/23/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 4/18/24 at 8:28 a.m. licensed practical nurse (LPN)-B stated nurses complete the skin checks on bath days. If there was anything abnormal, then the provider would be notified for cares and monitoring. Usually, a weekly skin assessment would trigger for nurses in the electronic medical record. LPN-B stated R8 was at risk for skin injury and verified there were not weekly skin assessments that triggered for R8. LPN-B further verified there was wound monitoring on bath day listed as a task but had never documented there before. When interviewed on 4/22/24 at 2:08 p.m., the Director of Nursing (DON) stated resident skin was monitored by all staff daily with cares. On bath days, NA's competed skin monitoring task and were expected to document in the tasks. If NAs found any skin concerns, redness, bruising, open areas, etc, they would report to the nurse. The nurse then would assess the area, document, and notify the provider. Monitoring skin with cares were important to catch any skin concern early and start treatment. A facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation revised 4/26/23, directed staff to accurately document observations and assessments of resident skin. Furthermore, a systematic skin inspection will be made daily by the nursing assistant assigned to those at risk for skin breakdown. The nursing assistant will report any abnormal findings to the licensed nurse.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43007 Based on observation, interview and document review, the facility failed to assess for and implement appropriate interventions to decrease the risk for falls for 4 of 4 residents (R189, R7, R29, R24) reviewed for falls. This failure led to actual harm for R189 when R189 obtained a right ankle fracture after a fall. Findings include: R189 R189's admission MDS dated [DATE], indicated R189 was admitted to the facility on [DATE], at risk for falls and had a fall with injury prior to admission. Further indicated, diagnosis of open reduction internal fixation (ORIF) of the left femur. R189's cognitive loss/dementia CAA dated 9/2/23, indicated R189 had confusion, disorientation, and forgetfulness and requires frequent reorientation, reassurance, and reminders to help make sense of things. The CAA lacked any interventions. R189's fall CAA dated 9/2/23, indicated R189 was at risk for falls related to being unable to ambulate without staff assistance due to unsteadiness, fall history within the last month prior to admission, and a fall after admission. R189's care plan dated 8/30/23, lacked any evidence of a fall care plan, fall history or any interventions to decrease the risk for falls. Further, the care plan lacked any evidence of what R189's ADL self care performance deficit was related to and had no interventions. R189's kardex dated 8/30/23, lacked any evidence of R189's fall risk status or interventions to prevent falls. Further, lacked evidence on how to assist R189 during transfers or ambulation. R189's fall assessment dated [DATE], indicated R189 was high risk for falls however, lacked evidence of an action plan to prevent/decrease the risk of falls. The facility Risk Management report dated 9/2/23 at 6:45 a.m., indicated R189 was found sitting on the floor of the bathroom. The report lacked any evidence of an assessment, root cause analysis, or any interventions implemented to prevent further falls. The report further indicated the physician wasn't notified regarding the incident until 1:34 p.m. R189's progress noted dated 8/30/23 at 2:30 p.m., indicated R189 was able to ambulate to the bathroom with walker and contact guard assistance from staff. R189's progress noted dated 8/31/23 at 1:09 a.m., inidcated R189 was limited assistance with ambulating to the bathroom with a walker and assist of one staff. (continued on next page)

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	245207	A. Building B. Wing	04/23/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R189's progress note dated 9/2/23 at 3:34 p.m., indicated R189 was found sitting on the floor of the bathroom with redness noted to right lower leg. R189's progress note dated 9/2/23 at 11:29 p.m., indicated R189 was unable to bear weight and the right ankle was examined at 8:00 p.m. The on-call provider was notified and an order was given to send R189 to the emergency room to obtain x-rays. The progress note further indicated emergency medical services (EMS) stated to the nurse R189's right ankle was broken. R189's progress note dated 9/3/23 at 1:44 a.m., indicated R189 was admitted to Lakeview hospital with a right broken ankle. During an interview on 04/18/24 at 2:41p.m., emergency medical technician (EMT) stated ,we were called between 10:00 p.m. and 12:00 a.m. to transport a resident with a possible infection however, when we arrived noted an obvious deformity to the residents' right leg, the leg was swollen twice the size, and purple in color. During an interview on 04/19/24 at 9:29 a.m., licensed practical nurse (LPN)-A stated R189 was found on the floor in the bathroom and complaining of pain to her legs. No immediate intervention was put into place to prevent further falls. R7 R7significant change Minimum Data Set (MDS) dated [DATE], indicated R7 had mild cognitive impairment, was at risk for falls related to impaired mobility and psychotropic medication use, and no history of falls. Further, the MDS indicated R7 was unable to walk in room [ROOM NUMBER] feet and required moderate assist for transfers and toileting. R7's fall Care Area Assessment (CAA) dated 1/16/24, indicated R7 was at high risk for falls due to psychoactive medication use. Lacked evidence of a history of falls. R7's care plan revised date 3/5/24, indicated R7 was at risk for falls related to impaired mobility, history of falls, and psychoactive medication use. Interventions included: remind resident not to bend over or to ask for assistance. As a result of falls on 2/2/24 and 2/5/24 the resident received education to call for assist to prevent falls. The care plan lacked evidence of any new potential effective interventions for the falls on 2/1/24 and 2/5/24 to prevent further falls. The care plan lacked evidence of the falls on 2/4/24 and 4/12/24 or any interventions implemented to prevent any further falls. R7's order summary dated 4/22/24, indicated R7 had orders for Aspirin Enteric Coated (EC) 81 milligrams (mg) one tablet one time a day and Plavix 75mg one tablet one time a day, which both medications can increase risk for bleeding. Further, R7's order summary indicated R7 had an order for Bupropion HCL Extended Release (ER) 24 hour 150mg (medication used for major depression) one tablet one time a day, which has a side effect of dizziness. Trazodone 50mg (medication used for insomnia) one tablet one time a day, which has side effects of weakness and tiredness. Quetiapine Fumarate 150mg (medication used to treat mental/mood conditions) one tablet one time daily, which has side effect of orthostatic hypotension (a sudden drop in blood pressure when someone stands up). Buprpion HCL ER, Trazodone, and Quetiapine Fumarate can increase the risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R7's admission record printed 4/22/24, included diagnosis of osteoarthritis, osteomyelitis, and muscle weakness. These diagnosis places the resident at increase risk for falls and/or injuries due to a fall. Fall 2/1/24 R7's progress note dated 2/1/24 at 6:40 p.m., indicated R7 was in room, standing with her walker with no assistance. The staff entered the room however, R7 began to fall and staff were unable to break the fall. A request was made for the facility Risk Management for the incident on 2/1/24 however, did not receive. The care plan lacked evidence of any new potential effective interventions for the falls on 2/1/24. Fall 2/4/24 R7's progress note dated 2/4/24 at 3:47 p.m., indicated R7 was found in room with recliner in the up most position with R7's buttocks half on the recliner and half off the recliner. The nursing assistant was unable to help R7 into the recliner and had to lower R7 to the floor after attempting to use the stand lift to adjust R7 back into the recliner. The progress note lacked evidence of an immediate intervention to prevent further falls. A request was made for the facility Risk Management for the incident on 2/4/24, however, did not receive. The care plan lacked evidence of the fall on 2/4/24 or any interventions implemented to prevent any further falls from the recliner. Fall 2/5/24 R7's progress note dated 2/5/24 at 10:15 a.m., indicated R7 was found on floor next to her recliner. R7 stated she was trying to get into the wheelchair from the recliner. The progress note lacked evidence of an immediate intervention to prevent further falls. R7's fall assessment dated [DATE], indicated R7 was at risk for falls and lacked evidence of any interventions put into place to prevent further falls. The facility Risk Management dated 2/5/24, indicated R7 was found on the floor. R7 stated she was trying to get into her wheelchair from the recliner and just slipped and fell . The report lacked any evidence of intervention put into place to prevent further falls. Fall 4/12/24 R7's progress note dated 4/12/24 at 3:43 p.m. indicated R7 was found on floor laying on her back close to her recliner and the recliner was at the highest position with the wheelchair next to the recliner.The progress note lacked evidence of an immediate intervention to prevent further falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility Risk Management dated 4/12/24, indicated R7 was found on the floor laying on her back closer to the recliner with the recliner at the highest position. The report lacked any evidence of new intervention to prevent further falls. The care plan lacked evidence of the falls on 4/12/24 or any interventions implemented to prevent any further falls. During an interview on 4/22/24 at 3:55 p.m., the nurse practitioner (NP) stated any further falls for R7 could lead to serious injury/harm without new interventions implemented due to R7's history of falls with injury, her diagnosis, and medication usage. Further stated, any resident in a long-term care facility was at risk for serious injury from repeated falls. R29 R29's quarterly MDS dated [DATE], indicated R29 had moderatecognitive impairment, was at risk for falls due to one fall since admission, and was unable to walk 10 feet in room without moderate assistance. R29's fall CAA dated 10/20/23, indicated R29 was at risk for falls related to impaired mobility, incontinence, and psychoactive therapy. Interventions included interdisciplinary team (IDT) to monitor resident and update care plan as needed, staff to ensure to toilet resident in a timely manner, keep resident safe and injury free, and monitor for effectiveness of psychoactive medications. R29's care plan revised on 3/12/24, indicated R29 was at risk for falls related to history of repeated falls as evidence by unsteady gait. The care plan lacked any evidence of new interventions for the 4/15/24 fall. R29's fall assessment on 4/15/24, indicated R29 was high risk for falls however, lacked evidence of any interventions put into place to prevent further falls. The facility Risk Management dated 4/15/24 at 7:00 a.m., indicated R29 was found on the floor at the foot of his bed. R29 stated he was trying to get some pants and just fell . The report lacked evidence of any new interventions to prevent further falls. R29's progress note dated 4/15/24 at 7:30 a.m., indicated R29 was found on the floor at the foot of his bed. The progress note lacked evidence of an immediate intervention to prevent further falls. 44647 R24 R24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R24 was cognitively intact and had diagnoses of congestive heart failure, atrial fibrillation, vascular disease, and weakness. R24 required assistance of a walker and wheelchair for mobility and for rolling left to right in bed. Furthermore R24's MDS indicated R24 required and had a recent fall with injury. R24's fall CAA dated 1/8/24, indicated R4 was at risk for falls and fall related injuries due to antidepressant, opioids, and diuretic medication use. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R24's nursing progress notes indicated: -on 3/27/24 at 7:20 a.m., R24 was found sitting on the floor next to the bed in between the bed and the window. R24 stated they had rolled over in bed to turn off alarm clock and just fell out of bed. R24 was assessed for injury. R24 was on blood thinners and hit their head. R24 had a rape sized bump on left side of forehead, bleeding on face between lip and nostril, a large skin tear to right arm, and swelling and bruising to left knee. R24 sent to emergency room for evaluation. -on 3/27/34 at 11:30 p.m., R24 returned from the emergency room with diagnoses of closed head injury, traumatic hematoma, skin tear to right arm and facial laceration. R24's fall incident report dated 3/27/24, indicated R24 had rolled out of bed when attempting to shut off alarm clock. R24 was sent to emergency room due to hitting head and on blood thinners. R24's report further indicated no injuries were observed at time of incident and R24 was alert and orientated. R24's fall incident lacked any root cause or care plan interventions placed. R24's interdisciplinary team (IDT) follow up note dated 4/1/24, indicated IDT reviewed the incident and education was provided to R24 to ask for help if they were not able to reach alarm clock. R24's physical devices and/or Restraint Evaluation dated 4/4/24, indicated grab bars were requested from resident and family to assist with safe bed mobility. Assessment concluded bars did not restrict movement and education provided to patient and family. R24's care plan revised on 4/9/24, indicated R24 had an actual fall with serious injury related to poor balance and coordination. Interventions included educate and instruct resident and family on safe use of assistive devices, educate resident not to bend over and pick up dropped items and use grabber or ask for assistance. Furthermore, R24's care plan indicated the use of grab/assist bars on bed related to fall risk and instructed staff to educate resident and family risks and benefits, any concerns with use of the bars. R24's Kardex dated 4/17/24, directed staff to ensure resident was wearing appropriate footwear when ambulating or mobilizing wheelchair and encourage resident not to bend over to pick up items- encourage use of grabber or ask for assistance. An observation on 4/18/24 at 2:00 p.m., R24 was laying in bed with the head of bed elevated. On R24's left was a bedside table located in-between the bed and wall with window. On the bedside table was R24's alarm clock. The bedside table was located by the head of the bed and for R24 to reach the alarm, they would need to reach over their left shoulder behind them. R24's bed had a grab bar on R24's right side, but not one on the left side where the alarm clock and bedside table were. R24's reacher was noted to be out of reach and standing next to a dresser to the right of R24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	When interviewed on 4/18/24 at 2:00 p.m., R24 stated she was trying to turn off the alarm clock and just fell out of bed. R24 stated it happened so fast, she wasn't sure what she hit or how she landed. R24 stated she would like to use the alarm clock but was too scared and she didn't want to roll out of bed again. R24 stated after the fall, the bars were put up, but that job never got completed .they only put on one side, and that bar is loose. R24 took a hold of the grab bar that was placed on right side and shook it. The bar was very loose. R24 stated staff were aware and wasn't sure if the bar was going to be fixed or why the other side was not placed. R24 stated she still had bumps and bruising from the fall and pulled her hair back to show a lump that appeared to be scabbed over on the left forehead and her left knee which still had a lump and was a dark purplish color. When interviewed on 4/28/24 at 2:18 p.m., NA-A was aware of R24 rolling out of bed and stated R24 was bleeding from their face. NA-A stated R24 was independent and was not a fall risk. R24 wasn't considered a fall risk as she was able to transfer independently, get dressed, and was able to get herself out for meals. NA-A further stated they were not sure how to know which residents were considered a fall risk and stated residents who have a lot of falls and have touch call lights would be considered a fall risk. NA-A further stated the grab bar was placed to help R24 getting out of bed. NA-A thought they were placed on both sides. When interviewed on 4/18/24 at 2:31 p.m., LPN-C stated R24 rolled out of bed when trying to turn off the alarm clock. R24 had not had prior falls to this and R24 and family requested grab bars to be placed to help assist with bed mobility and reaching for the alarm clock. LPN-C further stated there wasn't any specific side or not but thought there were two on the bed. When interviewed on 4/19/24 at 9:59 a.m., maintenance personal stated when nursing staff complete the assessment for safety, a work order was placed for grab bars. Grab bars were checked quarterly during room checks. The maintenance personal further stated R24's loose bar was replaced as there was a suction part that was no longer functioning. A follow up interview on 4/22/24 at 9:59 a.m., maintenance personal verified the work order for R24's grab bars indicated for both sides. Maintenance personal explained he had only the right one available to place. The bars and beds were no longer manufactured so new ones were not able to be ordered. There wasn't a left side available to put on and nursing staff on that day were told and said it was ok. When interviewed on 4/22/24 at 2:08 p.m., the Director of nursing (DON) stated the care plan, Kardex, and wing assignment sheets were how staff knew what residents were at risk for falls and what interventions were needed. The Kardex and assignment sheets could be updated by any of the nurses when there was a change. DON expected staff to be aware of residents at risk for falls. DON further stated all falls were reviewed in the daily IDT meetings and if new interventions were needed, the care plan and Kardex was updated. DON wasn't sure why only one rail was placed and thought it may have been placed only on the side R24 got out of bed. DON expected fall interventions to be in place for residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/19/24 at 11:11 a.m., nursing assistant (NA)-B stated had been working at the facility for about a month. NA-B knew residents were a fall risk by fall risk being posted on residents' doors or in their rooms, for example on bathroom doors. NA-B further stated residents who were at risk for falls wore a wristband or wore a band around their ankle. NA-B stated residents' charts stated if they were at risk for falls, and NA-B was not aware of any residents who were a fall risk on the hallway being worked. NA-B stated when a resident fell , the staff kept the resident on the floor until the nurse could get the resident's vitals and make sure the resident was okay. Staff assisted the resident back into bed if they were okay or called the hospital if they were not okay. NA-B stated had education regarding falls and fall prevention during nursing assistant certification but doesn't recall any fall or fall prevention education from the facility. After completing medical record review and review of the resident rooms, noted several residents on NA-B assignment were at risk for falls including R24. During an interview on 04/19/24 at 9:46 a.m., director of nursing (DON) stated when a resident falls the staff should put an immediate intervention in place after an assessment of the fall and then IDT would review and change the intervention and update the care plan if appropriate. Further, the DON stated the staff should follow the fall policy. The facility Fall Prevention and Management policy dated 4/2/24, indicated proactive approach before a fall occurs: 1. On admission or readmission, review the applicable documents and additional admit information documentation for fall risk factors. 2. Complete the Falls Tool UDA for fall screening and identifying fall risk factors. 3. Care Plan the appropriate interventions, including personalizing all specify areas. 4. Communicate fall risks and interventions to prevent a fall before it occurs per the 24-hour report, care plan, and kardex, daily stand-up meeting, and/or Fall Committee meetings. 5. Communicate any identified environmental changes and/or referral needs. Procedure for a fallen resident: - A nurse must observe the resident and perform a full-body exam to determine if there may be suspected injury and direct whether to move the resident. - Notify the physician and resident representative of the incident. - After the initial documentation of the incident in the incident report this will be done in the progress note (PN) - Incident. Document the physician's comments in the medical record. - Communicate that a fall has occurred during shift change and daily stand-up meetings. - Review and update the Care Plan with any changes/new interventions. - Continue to monitor condition and the effectiveness of the interventions.

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	245207	A. Building B. Wing	04/23/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on interview and record review the facility failed to ensure the consulting pharmacists recommendations were acted upon for 1 of 3 residents (R24) reviewed for taking anticoagulation medication. Findings include: R24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R24 was cognitively intact and had diagnoses of congestive heart failure and atrial fibrillation (rapid heartbeat). Furthermore R24's MDS indicated R24 was on an anticoagulation medication (medication used to thin the blood and prevent blood clots). R24's nursing and provider orders reviewed on 4/16/24, indicated R24 required warfarin (anticoagulant medication) 3 milligrams (mg) on Mondays and 4mg daily Tuesday- Sunday. R24's nursing and provider orders lacked indication R24 required monitoring for bleeding, bruising or other side effects of an anticoagulation medication. R24's care plan revised on 4/9/24, lacked indication R24 had monitoring for bleeding, bruising or other side effects of an anticoagulation medication. R24's monthly medication regimen review dated 12/8/24, indicated R24 was on a warfarin and the recommended staff to monitor for signs and symptoms of bleeding and bruising; monitor for thromboembolism (blood clots). R24's pharmacy progress notes from 1/2024- 3/2024, indicated R24 had no medication irregularities. When interviewed on 4/18/24 at 1:45 p.m., registered nurse (RN)-B stated pharmacy sends the recommendations to the nurse practitioner. The nurse practitioner then determines what they want to do from there. RN-B further stated if the nurse practitioner wanted monitoring, it would be ordered. When interviewed on 4/22/24 at 1:15 p.m., the Director of Nursing (DON) stated pharmacy recomendations were recieved monthly. The DON works on them or delegates them out. They go into a folder for the provider right away. Usually the provider is given a month to review and act on the recomendation. If not complted, the pharmacist will let us know and would follow up with the physician again. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 4/22/24, at 2:48 p.m. the consultant pharmacist stated monthly reviews were completed for all residents. During the reviews, high risk medications, such as anticoagulant medications were reviewed to ensure appropriate dosing, indications, and any monitoring was in place. The consulting pharmacist further stated recommendations were needed for anticoagulant monitoring such as bleeding, excessive bruising, etc and should be included in the resident care plan. If the care plan did not have the monitoring during the monthly review, they would put a recommendation in. If the recommendation was placed and not completed, it would be marked as pending, and then reviewed or followed up with the provider. However, the monitoring of side effects was not dependent on a provider order and would go to the nurse to implement and wouldn't be marked as pending. I would expect that to be implemented when received. The consulting pharmacist stated R24 was on coumadin therapy since 12/2023 and acknowledged there had not been any further direction or follow up on the initial recommendation for anticoagulation monitoring since one was sent in December. A facility policy titled Pharmacy Services revised 8/29/23, directed the pharmacist to report any irregularities to the attending physician or the director of nursing or both. The reports must be acted upon, and follow-up documentation maintained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on interview and record review the facility failed to ensure adequate monitoring was in place for 3 of 3 residents (R24, R91, R31)reviewed for unnecessary medications. Furthermore, the facility failed to ensure duplicative medications were prescribed for 1 of 5 residents (R91) reviewed for unnecessary medications. Findings include: R24 R24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R24 was cognitively intact and had diagnoses of congestive heart failure and atrial fibrillation (rapid heartbeat). Furthermore R24's MDS indicated R24 was on an anticoagulation medication (medication used to thin the blood and prevent blood clots). R24's medication regimen review dated 12/8/24, indicated R24 was on a warfarin and the recommended staff to monitor for signs and symptoms of bleeding and bruising; monitor for thromboembolism (blood clots). R24's nursing and provider orders reviewed on 4/16/24, indicated R24 required warfarin (anticoagulant medication) 3 milligrams (mg) on Mondays and 4mg daily Tuesday- Sunday. R24's nursing and provider orders lacked indication R24 required monitoring for bleeding, bruising or other side effects of an anticoagulation medication. R24's care plan revised on 4/9/24, lacked indication R24 had monitoring for bleeding, bruising or other side effects of an anticoagulation medication. R91 R91's admission MDS dated [DATE], indicated R91 was cognitively intact and had diagnoses of skin infection of lower extremity, arterial fibrillation, and diabetes. Furthermore R91's MDS indicated R91 required anticoagulation medication. R91's Potentially and Significant Medicaion Issues assessment dated [DATE], indicated no medicaton issues identified. R91's nursing and provider orders reviewed on 4/16/24, indicated R91 required the following: -Eliquis (anticoagulant medication) 5mg twice daily for blood thinning -clotrimazole topical cream1% (ointment to treat fungal infection) apply to affected area topically two times a day for candida yeast skin infection -Nystatin cream 100000units/gram (ointment to treat fungal infection) apply under breast/abdominal folds topically every day and evening shift for rash (continued on next page)

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	245207	A. Building B. Wing	04/23/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R91's nursing and provider orders lacked indication R91 had monitoring for bleeding, bruising or other side effects of an anticoagulation medication. R91's medication regimen review dated 4/7/24, requested clarification on the nystatin cream and clotrimazole cream and recommended monitoring for signs/symptoms of bleeding or bruising and monitor for thromboembolism (blood clot). R91's care plan initiated 4/10/24, lacked indication R91 had monitoring for bleeding, bruising or other side effects of an anticoagulation medication. When interviewed on 4/18/24 at 11:00 a.m., licensed practical nurse (LPN)-B stated any resident who takes an anticoagulation should have monitoring in place for bleeding or bruising. LPN-B further stated the monitoring may be in an order but otherwise was included in the care plan. LPN-B further stated upon admission, the admitting nurse reviews and enters the medication orders and a second person signs off on them. Nurses look to ensure high risk medications have monitoring in place, if any of them need stop dates, or if there are any duplicative medications. LPN-B verified whoever was doing the checks or notices something was missing or duplicative medications, clarification from the provider is needed. LPN-B verified no anticoagulation monitoring was in place for R24 and R91. LPN-B further verified R91 had both nystatin cream and clotrimazole cream and said they should have been clarified. When interviewed on 4/18/24 at 1:45 p.m., registered nurse (RN)-B stated nursing monitors for bruising, but there was no documentation of it. pharmacy sends the recommendations to the nurse practitioner. The nurse practitioner determined what they want to do with the recommendation. RN-B further stated if the nurse practitioner wanted monitoring, it would be ordered. RN-B further stated R91 was not at the facility long enough for a pharmacy review. R91 came with orders from the hospital and the nurse practitioner signed off on them. If there were one's the NP didn't want, they wouldn't have been signed off on. 42586 Findings include: R31's admission Minimum Data Set (MDS) dated [DATE], indicated R31 had intact cognition and diagnoses of bladder cancer, difficulty walking, and stroke. It further indicated R31 required staff assistance with activities of daily living (ADL) and mobility and was taking an anticoagulant (AC). R31's physician's orders dated 4/1/24, indicated Apixaban oral tablet 2.5 milligrams (mg). Give 1 tablet by mouth every morning and at bedtime for persistent atrial fibrillation. R31's Potentially Clinically Significant Medication Issues report dated 4/1/24, indicated a review of R31's medications had been done and there were no concerns. R31's care plan dated 4/1/24, lacked any indication of AC side effect monitoring. R31's medical record lacked any indication of AC side effect monitoring. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 4/18/24 at 8:23 a.m., registered nurse (RN)-A verified R31 did not have any documentation of monitoring for AC side effects. RN-A further stated I know off hand to look for it (side effects) and we can always document it in the progress notes. When interviewed on 4/22/24, at 2:48 p.m. the consultant pharmacist stated during monthly reviews high risk medications, such as anticoagulant medications were reviewed to ensure appropriate dosing, indications, and any monitoring was in place. The consulting pharmacist further stated recommendations were needed for anticoagulant monitoring such as bleeding, excessive bruising, etc. and should be included in the resident care plan. If the care plan did not have the monitoring during the monthly review, a recommendation was placed. If the recommendation not completed, it would be marked as pending, and then reviewed or followed up with the provider. However, the monitoring of side effects was not dependent on a provider order and would go to the nurse to implement the recommendation. I would expect that to be implemented when received. The consulting pharmacist further stated when a resident was newly admitted , they would review the medications after the first day or two. Any recommendations would be sent to the Director of Nursing (DON) and the nurse practitioner. The pharmacist stated notification was sent on 4/7/24, for R91's duplicative medications. The consulting pharmacist stated there was some over prescribing of the same kind of medications. The pharmacist further stated usually there was a quick response from the nurse practitioner but had not received a response yet. When interviewed on 4/22/24,at 1:58 p.m., the DON stated anticoagulation monitoring was not documented but should be included in the resident plan of care. Any skin monitoring was compelted during cares and on bath days. Upon admission, the pharmacist and the provider both review medications to ensure there are not concerns. Staff are always able to reach out to providers for clarification as well. DON expected staff to clarify R91 Nystatin and clotrimazole ointment orders. A policy for high risk medication side effect monitoring was requested and received but did not address side effect monitoring for AC's.

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	245207	A. Building B. Wing	04/23/2024

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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. 44647 Based on interview and record review, the facility failed to employ either a full-time registered dietitian (RD) or a qualified dietary manager (DM) to carry out the functions of the food and nutrition service. This had the potential to affect all 39 residents who resided in the facility. Findings include: The facility's undated list of hires did not include a DM. The interim dietary supervisor (DS)'s qualifications for a dietary manager was requested however was not received. When interviewed on 4/15/24 at 1:08 p.m., the DS stated there was not a DM currently employed at the facility. DS was a DS at a sister facility and was currently working both facilities. DS further stated there had been a lot of turnover in the kitchen staff and the facility was working on hiring. A follow up interview on 4/18/24 at 10:46 a.m., DS stated he had been at the facility for about a month trying to help. DS further stated he had food safety manager certificate, however, was not able to find it. When interviewed on 4/18/24, the RD stated they did not work full time at the facility and were on site twice weekly on Tuesdays and Thursdays. When interviewed on 4/22/24 at 1:39 p.m., the administrator verified there had not been a dietary director for a month or so and that was why DS was helping in the kitchen. The administrator further stated there was a new DM hired but was unsure of a start date as they were waiting on a background check.

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	245207	A. Building B. Wing	04/23/2024

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 44647 Based on observation, interview, and record review the facility failed to ensure sufficient support staff with the appropriate competencies to carry out the functions of the food and nutrition services. This had the potential to affect all 39 residents who reside in the facility. Findings include: The facility's undated list of hires did not include a dietary manager (DM). An undated facility document titled Annual and New Hire Education Dietary indicated all dietary staff had required training titled Basics of Food Safety in Long Term Care Facilities and IDDSI training for safe swallowing. Dietary aide (DA)-A's new hire education dated 4/18/24, lacked indication DA-A had completed the required training for dietary staff titled Basics of Food Safety in Long Term Care Facilities and IDDSI training for safe swallowing. An observation on 4/16/24 at 8:06 a.m., residents were being served breakfast in the dining room. There was no daily menu posted in the dining room. DA-A was serving up cold cereal, yogurt, and toast. DA-A stated there was no cook this morning due to an ill call. DA-A stated she was on her own until 9:00 a.m., and she isn't a cook so breakfast was toast and cereal. DA-A stated she wasn't sure what breakfast was supposed to be. When interviewed on 4/15/24 at 12:50 p.m., cook-A stated they were working late to help with dishwashing as there wasn't enough staff. When interviewed on 4/15/24 at 1:08 p.m., dietary supervisor (DS) stated they had been coming to work at the facility for about a month to help as there was not a dietary manager (DM). DS was also working as a supervisor at a sister facility. When starting here, DS stated there was not a good process for labeling and dating foods or for ordering what was needed. DS stated he wanted to get some processes in place for ordering what was needed for menu items, labeling, and dating foods, and a kitchen cleaning schedule. DS stated he was working in the facility almost every day and stated there just was not enough staff or time to work on the needed processes. DS stated everyone was just trying to do their best with what they have. A follow up interview on 4/19/24 at 8:34 p.m., DA-A stated she had not had any education related to food service when hired and had initially started as a housekeeper. DA-A started working as a DA due to being short staffed in the kitchen. DA-A further stated she did not train with anyone and just jumped in as the help was needed. (continued on next page)

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	245207	A. Building B. Wing	04/23/2024

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A follow up interview on 4/19/24 at 9:06 a.m., DS stated he was aware of no cook on 4/16/24 but was scheduled at the other facility. DS stated if he came here, then no cook would be over there, so there was not a good solution. DS was not aware of the training DA-A received as DS was not here when DA-A was hired. DA-A was hired prior to DS starting at the facility and was initially a housekeeper and switched to kitchen a week or so ago. Furthermore, DS stated he tried to train as best they can and wasn't aware of any checklist or sign off, just what staff were assigned to in the online training. When interviewed on 4/22/24 at 1:39 p.m., the administrator expected any general education for dietary staff would come from the supervisor. The administrator further stated any further education would depend on the employee and their experience. A policy on kitchen training and requirements was requested however was not received.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on observation, interview and document review, the facility failed to serve menu items as listed and planned for 2 of 2 residents (R25, R8) reviewed for nutrition services. Findings include: R25's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, diagnoses of chronic obstructive pulmonary disease (COPD), dysphagia, and required set up/clean up assistance with eating. R25's care plan dated 3/1/24, indicated R25 had a nutritional problem related to end stage COPD and to encourage pleasure eating (foods of patient choice) for comfort. During interview on 4/16/24 at 2:31 p.m. R25 stated on Monday (4/15/24) he was supposed to get a Salisbury steak and potatoes for dinner but instead he received a bowl of soup and half a grilled cheese sandwich. During a follow up interview on 4/17/24 at 12:47 p.m., R25 stated a nursing assistant comes to his room before each meal and gives him two choices off the menu to pick from but he often doesn't get the option he picked. 44647 Resident #8 R8's quarterly MDS dated [DATE], indicated R8 was cognitively intact and had diagnoses of heart disease, kidney disease and high blood pressure. When interviewed on 4/15/24 at 1:35 p.m., R8 stated the food was not always great and there were not many choices. R8 further stated there were a lot of soup that we could have, but not a lot of other items. R8 further stated she preferred to eat in their room. Staff let them know what the two meal options were but didn't always get the request and often felt like they get whatever's left. An observation on 4/16/24 at 8:55 a.m., the menu posted in the common area on long term care unit indicated the menu for the week was week 4. (continued on next page)

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	245207	A. Building B. Wing	04/23/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 4/17/24 at 7:11 a.m., dietary supervisor (DS) stated they had been coming to the facility for about a month to help as there was no dietary manager (DM). DS stated it was difficult to follow what the previous DM was doing as they had been following their own menu. DS further stated the food that was available was not what the menu called for and DS was still working on the process to get on an ordering schedule that matched up with what the menu was supposed to be. DS verified the facility was supposed to be on week one menu and wasn't sure what was posted in the main areas. DS verified the menu was not being followed and the situation was a big mess that was taking time to figure out and did not realize how bad it was until he arrived. DS was not aware of how residents were asked what they wanted or when that was determined. DS cooked to what the census was, for example for 37 residents, they would cook 30 main dish and then 7 or so of the alternative. DS verified sometimes it doesn't work out as more want the alternative than the main and sometimes there wasn't enough. DS verified on 4/16/24, the alternative meal was Salisbury steak. DS stated more residents wanted that than the main dish and didn't have enough to deliver to some of the rooms. DS wasn't sure what was told to the residents or what options for those residents were provided. When interviewed on 4/17/24 at 7:26 a.m., dietary aide (DA)-A stated either the nursing assistants (NA) or DA's go around from room to room to ask what option residents would like. The residents who came to the dining room were asked when they come in. DA-A further stated there wasn't a copy of the menu given to residents ahead of time. There were items that were always easy to make like soup, sandwiches, salads. DA-A stated there wasn't a list however residents knew about it. When interviewed on 4/18/24 at 7:30 a.m., nursing assistant (NA)-A stated before meals, they check with the kitchen to see what is on the menu. Then they ask the residents. They let us know what they want and if they don't like the choices, they can ask for something else and we can check with the cook. NA-A further stated sometimes residents just want cold cereal for lunch. When interviewed on 4/22/24 at 1:39 p.m., the administrator expected kitchen staff to be following the menu as scheduled. Furthermore, the residents' preferences for food should be known and taken into consideration when preparing meals. A facility policy titled Menu Requirements- Food and Nutrition Services dated 12/6/23, directed staff to prepare menus at least one week in advance of when the meal was served, and temporary menu changes were kept to a minimum. A facility policy titled Resident Choice in Dining- Food and Nutrition dated 1/22/24, directed staff to ensure pre-planned menu items were available for each resident. Furthermore, the policy directed staff to ensure dining services take into consideration each resident preferences, ensure there were available food and drink options that align with the resident's needs and preferences when the primary and secondary options were not to the resident's liking, there was a process to communicate all food and drink options to the residents including having an ala-carte menu list available to residents.

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	245207	A. Building B. Wing	04/23/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview, and document review, the facility failed to ensure frozen and refrigerated food items were properly stored, labeled, and dated and disposed of after expiration date. Furthermore, the facility failed to ensure the ice machine and air vents were clean and sanitary. This deficient practice had the potential to affect all 39 residents who receive food from the kitchen. Findings include: Food Storage During the initial kitchen observation on 4/15/24, at 12:46 p.m., the walk-in freezer contained the following: -a Ziplock bag labeled corn beef hash dated 2/11/24. The contents of the bag were brown meat with crystals of ice that had formed on the meat and the inside of the bag. -a Ziplock bag labeled turkey dated 4/12/24. The contents of the bag were white meat with crystals of ice that had formed on the meat and the inside of the bag. -Two plastic tub containers labeled potato salad with a date of 3/20/24 and 3/12 -a plastic tub that stated seafood salad dated 3/22. -four foil containers with foil tops had no label to identify contents, but had a date of 3/20. The walk-in refrigerator contained the following: - a container of [NAME] strawberries. The strawberries contained a greenish black fuzzy substaines -a container of Sysco ham soup base had a label that stated opened on 1/21 and lacked a use by date. -a container of Sysco chicken-based soup had an open date of 1/6 and lacked a use by date. -a white container of cucumber salad had no open date or use by date. -a tray of brownies on a plate was sitting on a cart with no label or date on when they were made. (continued on next page)

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	245207	A. Building B. Wing	04/23/2024

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Good Samaritan Society - Stillwater	1119 Owens Street North Stillwater, MN 55082

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on 4/15/24 at 1:08 p.m., the dietary supervisor stated food storage was on a first in first out basis. So, items that are the oldest should be used first but wasn't sure of the system in the facility as they were helping from a sister facility. DS verified the frozen meat appeared to not be good any longer and wasn't sure if the date was when it was put in the freezer. The potato salads and seafood salad were regular menu items and DS stated those were homemade items and were not normally items to be frozen and they should be thrown out. DS had no idea what was in the foil pans and stated they needed to be thrown out. The DS verified the mold on the strawberries, containers of soup base, and cucumber salad. DS was not sure when the salad was made or the trays of deserts, but most likely should be thrown. DS stated currently there was no dietary manager (DM) and since coming to help at the facility DS was trying to figure out the ordering process and menus. DS stated the previous DM saved everything, which was not always a good thing as items get old. DS acknowledged there was not a good process for dating, labeling, and storing food. This was something DS needed to get in place. Clean vents A kitchen cleaning schedule was requested however was not provided. An observation on 4/17/24 at 7:11 a.m., DS was prepping for breakfast. Over the kitchen prep area were two air vents on the ceiling. The vents had large grey clumps of dust in the grates. Across from the vents were clean pitchers, plates, and trays. DS verified the grey clumps of dust and verified the air was blowing out of the vents. When interviewed on 4/17/24 at 7:30 a.m., DS stated there was no cleaning schedule for the kitchen. DS stated since coming to help, they had been trying to get the kitchen cleaned better but it was challenging with working both places and not having a lot of help. DS stated there was work to be done to ensure there was a more streamlined process as almost all the staff was new. Ice Machiene A facility document titled Work History Report dated 1/2024-3/2024, indicated ice machine inspection and cleaning was completed on 1/31/24 and 2/29/24. An observation on 4/17/24 at 8:13 a.m., the ice/water machine for resident use was in the dining room. On the spouts where ice and water were obtained, there were large amounts of crusty white substance on the tray and around both the water and ice spigots. The sides of the tray also had crusty white substance on it that ran down onto the cooler located under the machine. When interviewed on 4/18/24 at 11:50 a.m., the maintenance personal stated there were 2 ice machines, but only one for resident use. The ice/water machines were cleaned quarterly. The log indicated a cleaning was done in January for the ice/water machine in the dining room and were required to be cleaned quarterly. The resident ice/water machine was due to be cleaned this month. Maintenance personal stated the white substance was hard water and calcium build up and it happened quickly. They attempted to try to clean it more often if there was time, but it just builds up quickly and doesn't get cleaned until the next quarter. (continued on next page)

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	245207	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Stillwater	1119 Owens Street North Stillwater, MN 55082

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on 4/22/24 at 1:39 p.m., the administrator, stated he expected food to be dated and stored properly and there shouldn't be moldy items. Furthermore, staff were expected to follow the cleaning schedule for the kitchen and ice/water machines. If items needed to be cleaned more often, it should be completed. This was all important for sanitary and safe food for the residents. A facility policy titled Food Supply Storage revised 5/11/23, directed staff to ensure foods that have been opened or prepared were placed in an enclosed container, dated, labeled, and stored properly. Furthermore, leftovers or food items prepared for service that were not served were stored for use within 7 days. A facility policy titled Cleaning Schedule- Food and Nutrition Services revised 11/27/2023, directed staff post written daily, weekly and monthly cleaning assignments in the kitchen areas. Furthermore, the policy directed daily inspections of ceilings daily for dust and cobwebs, and for walls and vents to schedule a cleaning every 6 months. A facility policy titled Ice Machine Use and Maintenance dated 12/11/23, directed staff to clean, descale, and change filters according to the water/ice machine's manufacture recommendations. Furthermore, the policy indicated to adjust the frequency based upon use and conditions related to the machine (location, quality of water, etc.

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	245207	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to follow standard precautions, contact precautions, droplet precautions, and perform evidence-based hand hygiene for GI symptomatic residents for 4 of 4 (R4, R24, R13, and R91) reviewed for infection control practices. Findings include: R4's annual Minimum Data Set (MDS) dated [DATE], indicated she had intact cognition and had diagnoses of overactive bladder, kidney disease, diabetes, and muscle weakness. R4's Care Area Assessment (CAA) for functional abilities (self-care and mobility) dated 3/21/24, indicated R4 required assistance with activities of daily living (ADLs) and one or two staff assistance. R4's CAA for urinary incontinence and indwelling catheter dated 3/21/24, indicated R4 required assistance with toileting, had incontinence, and was at risk for developing UTIs. R4's care plan dated 4/28/21, indicated she had an ADL self-care deficit related to a history of UTIs and required extensive assistance of one with toilet use. Furthermore, the care plan identified R4's history of UTIs with a goal to remain free of UTI. R4's care plan listed interventions of monitoring, documenting, and reporting signs and symptoms of infection to the nurse and provider and encouraging fluid intake. During observation and interview on 4/17/24 between 7:20 a.m. and 7:44 a.m., nursing assistant (NA)-A entered R4's without performing hand hygiene. NA-A assisted R4 out of bed and into the bathroom. NA-A donned gloves and assisted R4 to stand up and pivot onto the toilet. NA-A assisted R4 with dressing her upper body, putting on deodorant, and cleaning her eyeglasses while NA-A continued to wear the same gloves. NA-A instructed R4 to use the grab bars to help herself stand up, and once R4 was standing upright, NA-A reached from behind and wiped R4's perineal (peri) area from back to front with disposable wipes. Then, reaching from the backside of R4's perineal area, NA-A wiped front to back. NA-A removed the gloves and disposed of the wipes and gloves in the garbage can, pulled up R4's pants, and did not perform hand hygiene. NA-A wheeled R4 in front of the sink to complete morning ADLs independently. When interviewed, NA-A verified no hand hygiene was performed prior to entering R4's room. NA-A stated it was important to clean from front to back and ensure any soap used was rinsed and ensure there was no feces for the prevention of UTIs. Additionally, NA-A stated, in reality, I should wash my hands coming into the room, before peri-cares, then do peri-cares with gloves, then remove gloves after peri-cares and wash my hands, and then wash my hands before leaving the room. NA-A stated it was difficult to perform peri-cares because R4 was standing awkwardly, but R4 had a bath later in the day. During interview on 4/17/24 at 7:50 a.m., R4 stated she recently had a UTI and was feeling fine. She denied symptoms of infection and acknowledged staff allowed her the opportunity to perform hand hygiene after bathroom use. (continued on next page)

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	245207	A. Building B. Wing	04/23/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 4/18/24 at 10:47 a.m., the infection preventionist (IP) stated staff were expected to perform hand hygiene before entering and exiting a resident room and before and after glove use to protect residents from infection. The IP stated staff should clean front to back for female residents during peri cares to prevent fungal skin infections and UTIs. During interview on 4/18/24 at 1:45 p.m., registered nurse (RN)-B stated when performing perineal cares on a female resident, staff were expected to wipe from front to back and use a clean side of a washcloth or wipe for each swipe. RN-B stated staff were expected to perform hand hygiene before cares, don gloves during cares, change gloves after perineal cares and perform hand hygiene before donning new gloves. During interview on 4/18/24 at 3:30 p.m., the director of nursing (DON) stated staff were expected to use standard precautions when providing cares for residents. Additionally, the DON stated the expectation was to perform hand hygiene upon entering and before leaving a resident's room and, for female residents during perineal cares, for staff to wipe from front to back. The DON stated the goal was to prevent infection and it would not be an acceptable practice to enter a resident's room without performing hand hygiene, nor would performing perineal cares by wiping back to front. 42586 Findings include: R91's admission Minimum Data Set (MDS) dated [DATE], indicated R91 had intact cognition and diagnoses of sepsis, chronic kidney disease (CKD), chronic respiratory failure with hypoxia, and urinary tract infection (UTI). It further indicated R91 required maximal assistance with toileting hygiene and was frequently incontinent of bowel. R91's care plan dated 4/4/24, indicated R91 had bowel incontinence related to Crohn's disease and Norovirus and an activities of daily living (ADL) self-care performance deficit related to incontinence cares with an intervention of R91 required extensive assistance of one staff dependent for hygiene with incontinent bowel movement. During observation on 4/17/24 at 9:00 a.m., nursing assistant (NA)-D used hand sanitizer, donned a gown, gloves, mask, and entered R91's room. NA-D then assisted R91 to use the bathroom and exited the room still wearing the same gloves, gown, and mask and went into the hallway outside R91's room. NA-D then removed her gown and gloves and threw them away in the bins in the hallway, used hand sanitizer, and walked down the hallway towards the nursing station. During an interview on 4/17/24 at 9:19 a.m., nursing assistant (NA)-D stated she was aware R91 was on gastrointestinal (GI) and contact precautions but wasn't sure why. NA-D further stated she had assisted R91 to use the bathroom and R91 had diarrhea so had also assisted her to clean up. NA-D verified she used hand sanitizer after removing her gloves and did not wash her hands with soap and water stating You should just use soap and water when you get the chance because we don't have time in between residents so hand sanitizer works the best. NA-D verifed there was a sign on R91's door indicating she was on GI and contact precautions and staff should wash their hands with soap and water when leaving the room. NA-D works with all the residents in the facility, not just on one unit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 4/17/24 at 1:44 p.m., LPN-A stated if a resident was on GI/contact precautions staff should wear a gown and gloves before entering the room. It was okay to use hand sanitizer when entering and exiting the room but you should alternate with washing your hands with soap and water if you can. During interview on 4/17/24 at 1:52 p.m., nurse manager registered nurse (RN)-B stated R91 was admitted with Norovirus and continued to have diarrhea so they put her on GI/contact precautions. RN-B stated these precautions required staff to wear a gown and gloves stating whatever the sign says. and that staff should be washing their hands with soap and water (not hand sanitizer) when leaving the room. 44647 R24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R24 was cognitively intact and had diagnoses of congestive heart failure, atrial fibrillation, vascular disease, and weakness. R24 required assistance of a walker and wheelchair for mobility and for rolling left to right in bed. Furthermore, R24 was continent of bowel and bladder and was assist of one to the bathroom. R24's nursing and provider order summary indicated: -on 4/15/24, R24 required a COVID-19, influenza, urine analysis, and stool sample for enteric pathogen -on 4/15/24, gastrointestinal (GI)/contact/respiratory/droplet isolation until labs return An observation on 4/15/24 at 2:32 p.m., R24's door was closed. Outside the door was an isolation cart and two white garbage cans. On top of the isolation cart was a bottle of hand sanitizer. On the wall above the isolation cart were two signs. One stated enhanced barrier droplet precautions and instructed staff to wear gown gloves, eyewear, and surgical mask upon entering and if completing an aerosol generating procedure a N95 mask was required. Below that sign was a sign that read contact precautions and directed staff to use GI precautions if loose stools or C-diff. When interviewed on 4/15/24 at 2:44 p.m., LPN-C stated R24 started having diarrhea, nausea, and fevers today. The provider was notified and labs for COVID-19, influenza were ordered, and a urine and stool sample needed to be collected and sent for testing. LPN-C stated TBP were started as R24 was having a COVID-19 test and stool testing for enteric pathogens. An observation on 4/15/24 at 6:26 p.m., nursing assistant (NA)-E exited R24's room with gown, gloves, eyewear, and surgical mask in place. NA-E removed their gown and with gloved hands lifted the garbage can lid and placed the gown inside. NA-E then removed gloves and lifted the garbage can lid and place them in there. NA-E then removed eyewear and placed on isolation cart before using the hand sanitizer on top of the cart to perform hand hygiene. NA-E had not worn an N-95 mask. Without using soap and water to wash hands, NA-E then knocked and entered room [ROOM NUMBER] to provide resident assistance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on 4/15/24 at 6:40 p.m., NA-E stated R24 had an unknown droplet infection as well as weakness and diarrhea. NA-E stated R24's tests were pending. NA-E verified the isolation signs outside of R24's room. The top one stated enhanced droplet precautions and verified just a surgical mask was ok. NA-E further stated if R24's COVID test returned positive then a N95 mask was needed, but test had not come back yet. NA-E verified the contact isolation sign outside R24's room directed to use GI precautions with loose stools. NA-E stated that indicated to use gown and gloves when entering the room. NA-E further stated washing hands with soap and water was always the best to do, but hand sanitizer was ok to use as well, even with GI precautions. An observation on 4/16/24 at 8:10a.m., laboratory technician (LT)-A was observed exiting R24's room with gown, gloves, eyewear, and N-95 mask in place. LT-A removed gloves and placed in the garbage can outside of the room. LT-A then removed N-95 mask and eyewear and placed into garbage. LT-A used hand sanitizer located on the isolation cart outside of R24's room and walked down the hallway and entered room [ROOM NUMBER]. When interviewed on 4/16/24 at 8:27 a.m., LT-A stated R24 had a blood draw and that was why she was in R24's room. R24 had a COVID-19 test pending and was aware R24 was having loose stools. LT-A further stated that was why R24 was on TBP. LT-A stated there was nothing different with isolation or hand hygiene for GI symptoms and acknowledged washing with soap and water was best, but you just use what you have so sometimes it was just hand sanitizer. An observation on 4/16/24 at 2:13 p.m., the enhanced barrier for droplet sign that was outside R24's room was removed. The orange contact isolation sign remained. When interviewed on 4/17/24 at 1:34 p.m., LPN-F stated they were not sure what was going on with R24 and was confused about why they are on TBP. In morning report, LPN-A was told R24's tests were negative and so TBP were removed. LPN-F had not been using any TBP all morning until an order was placed for enteric precautions an hour or so ago. LPN-F verified the signs, cart, and garbage bins outside of R24's room and stated I just didn't pay attention to them as I was told tests came back negative. LPN-F further verified GI precautions included gown, gloves and handwashing with soap and water. When interviewed on 4/17/24 at 1:44 p.m., the Director of Nursing (DON) stated residents with GI symptoms were placed on enteric precautions. Enteric precautions were contact precautions where hand washing with soap and water was expected. DON was aware of R91's norovirus and further stated they were admitted with it. DON was not aware of any other residents with GI symptoms except R24 and there were no trends in GI illness. DON stated staff were expected to complete handwashing when residents were in GI/contact TBP. If testing for infectious process was in place, the residents were treated as if they have the infection until a test was resulted. DON would also expect residents with pending COVID-19 tests to be in full droplet precautions and not in enhanced barrier precautions as staff were required to use precautions as if the resident had the infection until the test proved otherwise. R7significant change Minimum Data Set (MDS) dated [DATE], indicated R7 had mild cognitive impairment. (continued on next page)

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	245207	A. Building B. Wing	04/23/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 4/18/24 at 8:44 p.m., housekeeper (H)-A was cleaning R13's room. H-A swept the floors with a sweeper to the doorway and then took a broom and dustpan to sweep up and placed the dirt in the garbage on the housekeeping cart. Without hand hygiene, H-A then went to the clean linen room and took a towel and went back into R13's room and placed the towel in the bathroom. Without hand hygiene, H-A exited room and again went to the clean linen room and obtained sheets and brought back into R13's room. H-A proceeded to make R13's bed. At 8:59 a.m., H-A exited R13's room with no gloves and no hand hygiene was carrying R13's dirty bedspread that contained brown/tan substance on it that appeared to be bowl movement. The bedspread was not bagged but freely hanging in the open. The bedspread was brought to the soiled utility room and placed in a bin. Without hand hygiene, H-A left the soiled utility room and went to the clean linen room to obtain a clean bed spread and returned to R13's room to finish making the bed. After completing the bed, without hand hygiene, exited R13's room carrying a folded sheet and brought it back to the clean linen room. H-A then went to the cart and without hand hygiene placed a glove on the right hand only, obtained a wet washcloth from the cart and proceeded to clean high touch areas of R13's room. H-A then went back to the cart and placed washcloth in dirty linen bag attached to housekeeping cart and with same gloved hand took the toilet brush and went to clean the toilet. After completion, brought the brush back to place in the cart removed one glove and performed hand hygiene and entered room [ROOM NUMBER]'s room to clean. When interviewed on 4/18/24 at 9:35 a.m., H-A verified they only had one glove on and did not perform hand hygiene with each exit of R13's room or when exiting the soiled utility room. H-A stated they try to clean up the resident rooms and bring extra linens that were not used back to the clean linen. H-A had not been told that is not ok to do. H-A further acknowledged R13's bedspread had bowel movement on it and should have had gloves on and placed it in a bag before bringing to the soiled utility room. When interviewed on 4/18/24 at 11:50 a.m., housekeeping supervisor stated generally any linens were not touched by housekeepers unless turning over a room for discharge. HS expected staff to be wearing gloves when entering and exiting the room as well as when handling any soiled linens or towels. HS stated extra linens should not be brought out of resident rooms and placed back in storage as they were already placed on resident surfaces. All these things helped to prevent any spread of germs/bacteria. During interview on 4/18/24 at 10:47 a.m., the infection preventionist (IP) stated if a resident tested positive for something, staff were notified immediately to place the resident on isolation precautions and the resident's provider would be updated for further guidance regarding any type of outbreak testing. The IP stated enhanced barrier precautions (EBP) were initiated for residents with chronic wounds, pressure ulcers, surgical wounds and incisions, and catheterization. When asked when transmission based precautions (TBP) would be intitated for a resident, the IP stated, when they have a diagnosis. The IP was unsure what type of standing precautions could be implemented for the facility if a resident had gastrointestinal (GI) symptoms, such as diarrhea, and stated, I'm not aware of any standing orders for this facility for precautions, but for the other facility and during our regional infection preventionist call, the expectation is the resident be placed on contact or droplet or ehanced barrier precautions until we can rule that out. If a resident was GI precautions, the IP stated staff were expected to wear gloves, gown, and a mask for all direct cares with the resident. The IP stated handwashing should be done whenever going in and out of the resident's room to prevent cross contamination, and handwashing should be done if staff are providing cares with the resident. The IP stated hand sanitizer would be appropriate if staff are, going in and out of the room to just verbally speak to the resident. (continued on next page)

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	245207	A. Building B. Wing	04/23/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility policy titled Activities of Daily Living - Rehabilitation/Skilled Care and Long Term Care (R/S, LTC), dated 11/29/22, indicated any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. Furthermore, the policy indicated ADLs are those necessary tasks conducted in the normal course of a resident's daily life and included toileting, transferring on and off the toilet, use of bedpan, urinal or commode, cleansing after elimination, changing any protective pads, and adjusting clothing after toileting. A facility policy titled Standard and Transmission Based Precautions revised 4/2/24, indicated: -standard precautions were used to protect residents from all recognized and unrecognized sources of infection, blood, and bodily fluids. Standard precautions include hand hygiene and personal protective equipment (PPE) such as glove use. The policy directed all staff to use standard precautions with all residents when cleaning equipment or handling of potentially soiled items and entering/exiting rooms. -enhanced barrier precautions were used for residents with wounds or indwelling medical devices. Enhanced barrier was used only during high contact cares that involve close physical contact with the resident. -contact precautions will be used in addition to residents with a known or suspected infection or evidence of syndromes that represent an increased risk for contact transmission. Contact GI precautions should be used when GI illness was suspected. -droplet precautions will be used in addition to residents with a known or suspected infection with organisms transmitted by droplets generated by sneezing, coughing, or talking.

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	245207	A. Building B. Wing	04/23/2024

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on interview and document review, the facility failed to have a method or system to ensure the facility offered or provided updated vaccine per Centers for Disease Control (CDC) vaccination recommendations for 5 of 5 residents (R7, 18, R24, R30, R32) to ensure residents were appropriately vaccinated against pneumonia upon admission. This had the ability to affect all 37 residents. Findings include: Review of the current CDC pneumococcal vaccine guidelines located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for: 1) Adults 19-[AGE] years old with specified immunocompromising conditions, staff were to offer and/or provide: a) the PCV-20 at least 1 year after prior PCV-13, b) the PPSV-23 (dose 1) at least 8 weeks after prior PCV-13 and PPSV-23 (dose 2) at least 5 years after first dose of PPSV-23. Staff were to review the pneumococcal vaccine recommendations again when the resident turns [AGE] years old. 2) Adults [AGE] years of age or older, staff were to offer and/or provide based off previous vaccination status as shown below: a) If NO history of vaccination, offer and/or provide: aa) the PCV-20 OR bb) PCV-15 followed by PPSV-23 at least 1 year later. b) For PPSV-23 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PPSV-23 OR bb) PCV-15 at least 1 year after prior PPSV-23 c) For PCV-13 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PCV13 OR bb) PPSV-23 at least 1 year after prior PCV13 d) For PCV-13 vaccine (at any age) AND PPSV-23 BEFORE [AGE] years: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aa) PCV-20 at least 5 years after last pneumococcal vaccine dose OR bb) PPSV-23 at least 5 years after last pneumococcal vaccine dose e) Received PCV-13 at Any Age AND PPSV-23 AFTER Age [AGE] years: aa) Use shared clinical decision-making to decide whether to administer PCV20. If so, the dose of PCV-20 should be administered at least 5 years after the last pneumococcal vaccine. Review of 5 sampled residents for vaccinations identified: 1) R7 was [AGE] years old and admitted to the facility in November of 2023. R7 received the PPSV-23 on 3/1/10, and the PCV-13 on 10/17/16. Based on shared clinical decision-making, R7 should have been offered and/or received the PCV-20 at least 5 years after the last pneumococcal vaccine dose. R7's quarterly Minimum Data Set (MDS) dated [DATE], indicated she was up to date on her pneumococcal vaccinations. R7's electronic health record (EHR) lacked documentation of shared clinical decision-making regarding PCV-20 dose. 2) R18 was [AGE] years old and admitted to the facility in February of 2024. R18 received the PPSV-23 on 1/1/13 and 2/10/15, and the PCV-13 on 2/10/15. Based on shared clinical decision-making, R7 should have been offered and/or received the PCV-20 at least 5 years after the last pneumococcal vaccine dose. R18's significant change MDS dated [DATE], indicated he was up to date on his pneumococcal vaccinations. R18's electronic health record (EHR) lacked documentation of shared clinical decision-making regarding PCV-20 dose. 3) R24 was [AGE] years old and admitted to the facility in December of 2023. R24 received the PPSV-23 on 9/21/07, and the PCV-13 on 1/27/16. Based on shared clinical decision-making, R24 should have been offered and/or received the PCV-20 at least 5 years after the last pneumococcal vaccine dose. R24's quarterly MDS dated [DATE], indicated she was up to date on her pneumococcal vaccinations. R24's electronic health record (EHR) lacked documentation of shared clinical decision-making regarding PCV-20 dose. 4) R30 was [AGE] years old and admitted to the facility in March of 2024. R30 received the PPSV-23 on 11/15/18, and the PCV-13 on 11/15/18. Based on shared clinical decision-making, R30 should have been offered and/or received the PCV-20 at least 5 years after the last pneumococcal vaccine dose. R30's admission MDS dated [DATE], indicated she was up to date on her pneumococcal vaccinations. R30's electronic health record (EHR) lacked documentation of shared clinical decision-making regarding PCV-20 dose. 5) R32 was [AGE] years old and admitted to the facility in March of 2024. R24 received the PPSV-23 on 10/13/11, and the PCV-13 on 9/30/15. Based on shared clinical decision-making, R32 should have been offered and/or received the PCV-20 at least 5 years after the last pneumococcal vaccine dose. R32's admission MDS dated [DATE], indicated she was up to date on her pneumococcal vaccinations. R32's electronic health record (EHR) lacked documentation of shared clinical decision-making regarding PCV-20 dose. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 4/18/24 at 10:47 a.m., the infection preventionist (IP) stated the facility utilized the CDC's guidelines and Pneumorex Advisor application to determine if residents were eligible for pneumococcal vaccinations. The IP stated consent and risk versus benefits were discussed with new admissions and any eligible residents and a vaccine information sheet (VIS) was provided. The IP stated the facility utilized a standing order for vaccinations and documented administration in Point Click Care (PCC) once completed. When asked about R7, R18, R24, R30, and R32, the IP stated they were agreeable to receiving the additional vaccine dose, but the pharmacy was out. A review of R18's progress notes revealed a note dated 4/18/24 at 12:12 p.m., that indicated per primary provider recommendation, okay to give Pnemovac 20 if indicated per CDC guidelines. A review of R30's progress notes revealed a note dated 4/18/24 at 12:14 p.m., that indicated per primary provider recommendation, okay to give Pneumovac 20 if indicated per CDC guidelines. A review of R32's progress notes revealed a note dated 4/18/24 at 12:14 p.m., that indicated per primary provider recommendation, okay to give Pnemovac 20 if indicated per CDC guidelines. A facility policy titled Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, Other, AL, R/S, LTC, HBS- Enterprise dated 9/21/23, indicated the purpose was to provide residents and clients the opportunity to receive immunizations as they fit into their healthcare goals. The policy's procedure indicated upon admission, each resident and/or resident representative would receive the Vaccination Information Sheets (VIS) for influenza and pneumococcal vaccines and if the resident and/or resident representative consented to vaccination, the facility would ensure physician's order was obtained for the vaccine(s) to be administered, obtain written consent if required by state regulation, complete a vaccination screening prior to vaccine administration, and administer the vaccination or refer to provider or pharmacy for vaccine administration. If the resident and or resident represented chose not to be vaccinated after discussion of benefits, the facility would document declination. Furthermore, the policy indicated residents would be reviewed for vaccine eligibility on an ongoing basis as immunization recommendations changed and the admission steps would be followed for each vaccine each time eligibility was determined. Additionally, the policy indicated it is recommended that all residents receive pneumococcal vaccination(s) per CDC guidelines for eligibility and timing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Stillwater	1119 Owens Street North Stillwater, MN 55082

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 44647 Based on observation, interview, and record review the facility failed to ensure the facility's walk-in freezer was maintained to ensure water drippings and ice build up would not impact frozen food storage. This had the potential to impact all 39 residents who reside in the facility. Findings include: During the initial kitchen observation on 4/15/24 at 12:46 p.m., the walk-in freezer was observed. Inside the freezer, near the top, at the far end were two fans. The right one was in motion while the left one was not moving due to a large ice dam inside the fan. In the fan blades and grate the large ice dam extended from the fan down all three shelves to the floor of the freezer. The ice dam appeared to be frozen water that had dripped down and frozen as it went down, as it gotten smaller as it went down. As it extended down the shelves, the ice had frozen on to several unopened boxes located on the back three shelves. When interviewed on 4/15/24 at 1:08 p.m., the dietary supervisor (DS) verified the ice dam and stated it had been there since he started at the facility a few weeks ago. DS stated it was something to do with the fan and wasn't sure how long it had been that way. DS further stated maintenance had been aware, but nothing had gotten fixed yet. DS verified the boxed items on the back shelves and was not sure if it impacted the items inside. When interviewed on 4/18/24 at 11:50 p.m., the maintenance personal stated he was made aware of the ice dam in the freezer a week or so ago and wasn't sure how long it had been there. Maintenance personal further stated he had been working on trying to chip it away, but it just kept building up. Maintenance personal further stated they had some help from another facility yesterday and were able to get the ice dam cleaned out and determine what the problem was. A temporary fix was now in place until the needed part arrived. When interviewed on 4/22/24 at 1:39 p.m., the administrator had not been aware of the ice dam in the freezer and expected all equipment in the kitchen to be in good working condition. If something wasn't working, it should be followed up on in a timely manner. A policy for maintaining equipment was requested however was not received.