| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245207 | A. Building<br>B. Wing | 01/30/2025 |

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| Good Samaritan Society - Stillwater | 1119 Owens Street North<br>Stillwater, MN 55082 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51567<br><br>Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained to promote dignity for 1 of 1 resident (R21) observed with bare skin and undergarments visible from the hallway to other residents, visitors, and staff.<br><br>Findings include:<br><br>R21's admission Minimum Data Set (MDS) dated [DATE], identified R21 had severe cognitive impairment, displayed disorganized thinking, had physical behaviors directed towards others (sexual), that interfered with care, or social interactions, did not reject care, and required maximal assistance for activities of daily living (ADLs). Further, the MDS identified R21 was incontinent of both bowel and bladder, had diagnoses of dementia, Parkinson's disease, coronary artery disease (CAD), peripheral vascular disease (PVD), heart failure, and had a history of falls.<br><br>R21's Care Plan dated 1/28/25, lacked information regarding preserving privacy and dignity. The care plan indicated brief use for incontinence, check upon rising, before and after meals, at bedtime, on NOC rounds and as needed. R21 was incontinent of bowel and bladder and dependent on staff for hygiene. Furthermore, R21's care plan identified inappropriate sexual advances towards residents and staff with the intervention of providing care with two staff members but failed to identify how to preserve dignity while keeping R21 safe in between cares.<br><br>R21's Kardex dated 1/30/25, indicated staff ensured safety for R21 by offering to help resident lay down in bed after meals when tired and to provide a safe environment, R21 moved closer to the nursing station to increase observation on 12/31/24, and the door was to be left ajar to avoid isolation.<br><br>During an interview on 1/27/25 at 5:25 p.m., family member (FM)-A, stated, the last time she visited, R21 was lying in a wet brief in his room, and further stated her and her family were embarrassed seeing R21 in just a brief, and was also embarrassed for R21 because he would be embarrassed if he realized he was lying in a brief with the door open.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 1/28/25 at 1:15 p.m., R21 was lying in bed in his private room with the door wide open, and fully visible to the hallway. R21 had the overhead lights off, was wearing a t-shirt, cream colored brief, bare legs, pants pushed down to his socks, and a sheet and blanket pulled to the side. R21's room had a visible track installed on the ceiling which had metallic hooking devices, however, the room lacked privacy curtains.<br><br>During an observation on 1/28/25 at 1:21 p.m., social services designee (SS)-A walked past R21's room that had the door wide open, SS-A looked in R21's room, and kept walking.<br><br>During an observation on 1/28/25 at 1:23 p.m., SS-A walked back down the hall and looked in R21's room, but did not talk to staff regarding R21 laying in the bed in a t-shirt and brief and the blankets pushed aside.<br><br>During an observation on 1/28/25 1:29 p.m., nursing assistant (NA)-C walked past R21's room and did not look in R21's room. NA-C came back approximately 1:30 p.m., to answer R21's ringing telephone. NA-C handed R21 the phone and R21 answered the phone but stated no one is there. NA-C covered R21 with a blanket and he grabbed at her. At this time, the director of nursing, (DON), walked past and entered registered nurse (RN)-A's office. NA-C then covered R21 up with a blue blanket and R21 made inappropriate comments to NA-C and attempted to reach out and grab her. NA-C redirected his behavior and left the room leaving the door open.<br><br>During an observation on 1/28/25 between 1:44 p.m. and 1:48 p.m., R21 was lying in bed and remained covered with a blanket and the door was open.<br><br>During an observation on 1/28/25 at 1:51 p.m., trained medication aide, (TMA)-A walked by R21's room, R21 had removed his blanket and unfastened his brief on the left side. TMA-A closed the door without talking to resident or going inside.<br><br>During interview on 1/28/25 at 1:56 p.m., TMA-A stated R21 was at risk for falling, and the door should remain open for safety. TMA-A walked back to R21's door and confirmed with surveyor the door had been shut and remained shut during our interview outside R21's door. TMA-A opened the door during our interview. The brief was loosely on with no private areas visible for the staff and visitors in the hallway to see. TMA-A verified there was no curtain hanging to provide privacy.<br><br>During observation on 1/28/25 at 2:12 p.m., TMA-A exited R21's room carrying a trash bag containing a tan brief and left the door open. R21 was covered with a blue blanket.<br><br>During observation on 1/28/25 at 2:35 p.m., R21's door was open, and R21 was lying in bed, scratching left side of his hip. R21's pants were pushed to end of bed and the blanket was pushed aside. Health Unit Coordinator (HUC)-A came out of the office directly across from R21's room, looked into R21's room and introduced self to state surveyors then went back in the office. There were two staff and two visitors walking down the hall.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During observation on 1/28/25 at 2:42 p.m., NA-C walked down the hallway and shut R21's door. At 2:45 p.m. , NA-C returned to R21's room, went inside and closed the door behind her. NA-C opened the door and as she was leaving R21 was making inappropriate sexual comments and reached out asking for a rub down. R21 was covered with a blanket and NA-C closed the door. NA-C walked over to the nursing station and discussed the inappropriate comments and gestures to other NA's and began discussing dinner plans. At 2:59 p.m., R21 was moaning and could be heard from the hallway.<br><br>During an interview on 1/29/25 8:42 a.m., the DON, verified R21's door should be open due to being at risk for falls. Further R21's door could be partially shut to provide as much privacy as possible, but safety was first.<br><br>[NAME] Policy Resident Dignity-Rehab/Skilled, dated 12/11/24 and [NAME] Policy Falls Resource Packet-Rehab/Skilled 5/7/24. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586<br><br>Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident (R25) received assistance with shaving and nail care reviewed for activities of daily living (ADL).<br><br>Findings include:<br><br>R25's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition and a diagnosis of blindness. It further indicated R25 required supervision with personal hygiene.<br><br>R25's physician's orders dated 1/24/25, indicated weekly skin assessment, please check skin and document findings in the skin observation V-3, chart vital signs, trim nails and obtain weight, offer to shave resident if he wishes, every day shift on Friday.<br><br>R25's weekly skin observation dated 1/24/25, lacked documentation R25's nails were trimmed, he had been shaved, or that staff offered or he had refused.<br><br>R25's care plan indicated R25 had an ADL self care performance deficit related to a history of cerebral vascular accident (CVA), blindness evidenced by a shuffling, slow gait, and required more help with ADLs. It further indicated an intervention for staff to provide assistance with bed mobility, transfers, eating, dressing, toilet use and personal hygiene.<br><br>During observation and interview on 1/27/25 at 1:31 p.m., R25 was sitting in his recliner in his room. The fingernails on both hands were approximately a 1/2 an inch long and he had a few weeks worth of facial hair. R25 stated he wanted his fingernails to be trimmed and to be clean shaven. He wanted to keep his moustache.<br><br>During observation and interview on 1/28/25 at 2:00 p.m., R25 was sitting in his recliner and his fingernails on both hands were approximately a 1/2 inch long and he stated he would like them cut. He also stated he wasn't clean shaven and would like to be.<br><br>During interview on 1/29/25 at 6:40 a.m., nursing assistant (NA)-A stated NA's were responsible for trimming residents nails (who are not diabetic) and shaving resident's once a week on their bath day. There was no place to document it specifically, its just part of what they were supposed to do. If the resident refused, they should re-approach and let the nurse know.<br><br>During interview on 1/29/25 at 6:46 a.m. NA-B stated NA's were responsible for shaving and trimming (non-diabetic) residents nails and shaving them once a week on bath day. There was no specific place to document and if the resident refused they should re-approach 3 times then let the nurse know.<br><br>During interview on 1/29/25 at 9:05 a.m., licensensed practical nurse (LPN)-A verified R25's nails and facial hair were long (more 1-2 weeks growth). LPN-A also stated nursing assistants were responsible for trimming residents nails (non-diabetic) and shaving residents once a week on bath day. The nurses were responsible for documenting it had been completed and the NA's should let nurses know if a resident refuses.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 1/30/25 2:35 p.m., the director of nursing (DON) stated NA's were responsible for trimming resident's nails and shaving them once a week on bath day. They should also be documenting if the task was completed and if the resident refused, they should also re-approach, let the nurse know, and document the refusal.<br><br>A facility policy on ADL's dated 11/29/22, indicated the purpose of the policy was to provide residents with appropriate treatment and services to maintain or improve abilities in ADL for the well being of mind, body and soul |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647<br><br>Based on observation, interview and record review the facility failed to ensure bruising was monitored for 1 of 1 residents (R14) reviewed for bruises. The facility further failed to ensure interventions for edema care were implemented for 1 of 1 residents (R17) reviewed for edema.<br><br>Findings include:<br><br>R14's quarterly Minimum Data Set (MDS) dated [DATE], indicated R14 had moderate cognitive impairment and diagnoses of dementia and heart disease. Furthermore, R14 received an anticoagulation (AC, medication to thin the blood) daily.<br><br>R14's provider order summary indicated R14 required the following:<br><br>- on10/4/23, Eliquis (AC medication) 5 milligrams (mg) daily to prevent blood clots.<br><br>- on 5/28/24, weekly skin assessment every evening shift on Sundays.<br><br>-on 5/21/24, required monitoring due to AC use. Instructed staff to report to the provider blood in the urine or stools, severe headache, unusual bruising.<br><br>R14's care plan revised 5/21/24, indicated R14 was on AC therapy and directed staff to monitor resident based on clinical standards related to AC use and easily bruising.<br><br>R14's weekly skin assessment dated [DATE], indicated R14 was assessed for skin alterations including bruising, however lacked indication bruising was identified.<br><br>R14's weekly skin assessment dated [DATE], indicated R14 was assessed for skin alterations including bruising, however lacked indication bruising was identified.<br><br>R14's weekly skin assessment dated [DATE], indicated R14's skin alterations had resolved.<br><br>R14's medical record lacked indication of when R14's bruising was identified and/or monitored.<br><br>An observation on 1/27/25 at 2:58 p.m., R14 was sitting in their wheelchair. R14's left forearm had a purple quarter sized bruise. Below was a second purple bruise with yellowing in the middle. R14's right hand around the second knuckle had a dime size dark purple bruise.<br><br>When interviewed on 1/28/25 at 1:10 p.m., nursing assistant (NA)-A verified R14's bruises and stated R14 had them for a while. R14 was on blood thinners and always had bruises on their hands and arms. NA-A wasn't sure how she always gets the bumps and bruises, but believed they were from hanging on to the grab bars tightly and bumping her arms with repositioning.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | When interviewed on 1/29/25 at 12:09 p.m., licensed practical nurse (LPN)-A stated if bruising was noticed on a resident, staff attempted to determine when it happened and how it happened. LPN-A stated monitoring if the bruising was significant or suspicious, more investigation and monitoring would occur. LPN-A further stated it was common for residents on blood thinners to have bruising on their hands and arms so there may not be any specific monitoring orders in place however the bruising would be documented on the weekly skin assessments. LPN-A verified R14 had bruising and stated it was not unusual for R14 to have multiple bruises from bumping their hands or arms during repositioning and transfers. LPN-A verified there was no specific monitoring, just the weekly observations and stated one bruise goes away and another one comes.<br><br>When interviewed on 1/29/25 at 12:37 p.m., registered nurse (RN)- A stated all residents who are on AC medication have monitoring in place for bruising. RN-A further stated any bruising would also be noted on the weekly skin assessments. If bruising was noted during cares or in between the weekly assessments, a separate skin assessment would be completed. If the bruising was suspicious or very large the provider would be notified, and additional monitoring orders would be placed. RN-A stated R14 was prone to bruising on the hands or forearms as she was on an AC medication and often bumped the grab bars or the bedside table. RN-A wasn't aware if R14 had any bruising currently as the bruising comes and goes. RN-A further stated if they were not listed on the weekly skin assessment, R14 may have just gotten them and would expect an assessment done to document when they were identified.<br><br>When interviewed on 1/30/25 at 1:51 p.m., the Director of Nursing (DON) expected staff to identify any bruising on the weekly skin assessments for routine monitoring. If the bruise was large or abnormal, additional investigation or monitoring would also be in place.<br><br>A facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation revised 4/26/24, directed staff to monitor bruising weekly and any changes and or progress toward healing should be documented on the skin observation assessment.<br><br>42586<br><br>R17's significant change Minimum Data Set (MDS) dated [DATE], indicated R17's cognition was unable to be assessed and diagnoses of congestive heart failure (CHF) and localized edema. It further indicated R17 required supervision with dressing.<br><br>R17's physician's orders dated 3/23/23, indicated Tubi-grips (compression bandages) to bilateral lower legs, on in the morning, off at hour of sleep (HS), every day shift for edema.<br><br>R17's care plan dated 11/9/22, lacked any indication of R17 wearing Tubi grips on bilateral lower extremities, potential for excess fluid, or edema related to CHF.<br><br>R17's medication administration and treatment administration records (MAR/TAR) for the month of January 2025 lacked documentation R25's Tubi grips were being applied in the morning or removed in the evening.<br><br>During observation on 1/27/25 at 6:02 p.m., R17 was sitting in the dining room waiting for dinner. He was wearing slippers and the legs of his sweat pants were bunched up approximately 2-3 inches in which his bare ankles/lower legs were visible and he was not wearing Tubi grips.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During observation on 1/29/25 at 6:30 a.m., R17 was asleep in his recliner in his room. His legs were elevated on the foot rest and he was wearing bilateral Tubi grips.<br><br>During observation and interview on 1/29/25 at 6:46 a.m. NA-B verified R17's Tubi grips were on and stated they should have been removed last night before he went to bed. NA- further stated NA's were responsible for applying R17's Tubi grips each morning and removing them in the evening.<br><br>During interview on 1/29/25 at 9:05 a.m., licensed practical nurse (LPN)-A stated NA's were responsible for applying R17's Tubi grips in the morning and removing them at night when he goes to bed. They should also re-approach, let the nurse know, and document any refusals.<br><br>During interview on 1/30/25 2:35 p.m., the director of nursing (DON) stated nursing staff were responsible for ensuring R17's Tubi grips were applied during the day and removed at night and to document the task was completed. They were also expected to document refusals and let the nurse know.<br><br>A facility policy regarding monitoring for edema was received but didn't address the use of assistive devices such as compression socks, Tubi grips, etc. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51567<br><br>Based on observation, interview, and document review, the facility failed to fully assess and implement fall prevention interventions for 2 of 2 residents (R21, R187) reviewed for falls.<br><br>Findings include:<br><br>R21:<br><br>R21's Optional State Assessment (OSA) dated 1/5/25, indicated moderate cognitive impairment, did not have delusions or hallucinations, did not reject care, had other behavioral symptoms not directed toward others 1 to 3 days, required extensive assist with bed mobility, eating, and toileting and was dependent on staff for transfers.<br><br>R21's Admission Minimum Data Set (MDS) dated [DATE], indicated R21 was frequently incontinent of urine and always incontinent of bowels, had fallen in the month prior to admission, had fallen once since admission with no injuries.<br><br>R21's Medical Diagnosis form undated, indicated the following diagnoses: acute on chronic systolic heart failure, muscle weakness, unspecified dementia, and Parkinson's disease.<br><br>R21's care area assessment (CAA) dated 1/5/25, indicated R21 had an actual falls risk and would be addressed on the care plan. The assessment further indicated falls put R21 at risk for injuries like fractures or head injuries that could result in rehospitalization , further functional and cognitive decline, disability and even death and a referral to other disciplines was warranted including the provider, therapy, and nursing to help design and implement patient specific interventions and strategies like improving balance and strength to reduce the risk of falls.<br><br>R21's care plan dated 12/31/24, indicated R21 had an actual fall on 12/31/24, and had the following interventions: staff to offer to help resident lay down in bed after meals when tired (1/25/24), educate resident and family about safety reminders and what to do if a fall occurs, educate resident and family and IDT as to the causes of falls, remind resident not to bend over to pick up dropped items, encourage use of grabber or to ask for assistance, modify environment to maximize safety, call light in reach, tap call light placed for easier access for resident due to dementia, night light used to maximize resident safety, ensure and provide a safe environment moved closer to the nursing station on 12/31/24 to increase observation, leave the door ajar to avoid isolation, 1/20/24 cues and reminders to resident to wait for assistance and not self-transfer. 1/21NP review of falls with labs ordered, signage placed on bathroom door to remind resident to have staff assist to the bathroom, review bowel and bladder continence status and establish and or review toileting plan based on resident's needs. 1/20/25 toileting, check and change upon arising, before and after meals, bedtime and as needed. 1/30/25 wheelchair in locked position beside bed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R21's Kardex dated 1/28/25, indicated encourage and monitor independent interests, assist with resources as needed, turn on the TV, R21 liked to watch channels 37, 47, or cop shows, and action movies. Invite and remind resident of scheduled activities, assisting to and from locations as needed, and responds well to redirection. Attempts to self-transfer back to bed after meals, staff to offer to help resident lay down in bed after meals when tired 1/25/24. Provide a safe environment, move closer to the nursing station to increase observation, leave the door ajar to avoid isolation. 1/20/24 cues and reminders to resident to wait for assistance and not self-transfer, signage placed on bathroom door to remind resident to have staff assist to the bathroom. Place the call light in reach, use a night light, remind resident not to bend over to pick up dropped items. Encourage use of grabber or to ask for assistance.<br><br>R21's Falls Tool form dated 12/31/24 at 8:39 a.m., indicated R21 had one or more falls between 3 to 12 months ago, took two risk factor medications, had moderately impaired cognition, and risk factors included cognitive status, restlessness, confusion, poor memory, impulsive, and under the heading, Action Plan indicated, Refer to therapy.<br><br>R21's Falls Tool form dated 1/20/25 at 6:26 a.m., indicated R21 took two risk factor medications, appeared severely affected psychologically, had risk factors including, mobility and transfers related to impaired balance, and cognitive status problems of reduced insight. Under the heading, Action Plan was undocumented.<br><br>R21's Falls Tool dated 1/21/25 at 12:32 a.m., indicated R21 was at high risk for falling, had one or more falls in the last three months, took two risk factor medications, appeared severely affected psychologically, had severe cognitive impairment, had restlessness, reduced insight, delirium, confusion, poor memory, was impulsive, withdrawn, disorientated, had difficulty following instructions and had sleep problems, used equipment unsafely, forgot to use equipment, had medical problems, and continence problems, multiple falls during a shift and under the heading, Action Plan was undocumented and under the heading, Multiple Falls indicated the care plan was updated to include the wheelchair had anti roll-back brakes applied.<br><br>R21's Group and Self-Directed Activities 30 day look back form from 1/29/25, indicated no data was found for activities, community, creative, educational/cognitive, physical, sensory stimulation, social, and spiritual activities.<br><br>R21's one to one Activities 30 day look back form from 1/29/25, indicated R21 had eye contact, and a social activity on 12/31/24. Further, the forms lacked documentation R21 had any spiritual, sensory, physical, educational/cognitive, creative, or community activities. No additional activities were documented.<br><br>R21's Risk Management Report dated 1/20/25 at 6:17 a.m., indicated R21 was on the floor in the bathroom. R21 stated he was getting up and fell . R21 was assessed for injury and moved back to bed by Hoyer lift. He was not transferred to the hospital. Under the heading, Predisposing Situation Factors not applicable was documented, no medications identified as factors. IDT reviewed the incident on 1/20/25.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R21's Risk Management Report dated 1/20/25 at 11:44 p.m., indicated R21 fell in the bathroom and was found between the sink and the toilet lying on his back. His right pointer finger had a 1 cm x 2 cm cut that was bleeding when staff found him. A bruise formed on the back of his head. The fall could not be described by R21. Paramedics were called and assessed R21 and was not transferred to the hospital. Under the heading, Injury Type no injuries observed at time of incident was documented. Under the heading, Predisposing Situation Factors other, unable to determine if resident was using a device at time of fall, and no medications were documented as factors to the fall. The risk management document does not identify resident had a fall within the past 24 hours, R21's had fallen at 6:17 a.m. and IDT reviewed the incident on 1/21/25.<br><br>R21's Risk Management Report dated 1/25/25 at 10:01 a.m., indicated R21 was found on the floor next to his bed with his head against the nightstand. Under the heading, Injuries Observed at Time of Incident Other and back of head were documented. The note documented on 1/25/25 stated R21 was trying to self-transfer to bed from wheelchair. IDT reviewed the incident on 1/28/25.<br><br>R21's progress notes dated 12/31/24 at 11:15 a.m., indicated R21 arrived back to the facility from the emergency room .<br><br>R21's progress notes dated 12/31/24 at 11:34 a.m., indicated the after-visit summary was due to a fall and the CT and x-rays showed no broken bones. Progress notes from 12/31/24, lacked information regarding R21's fall.<br><br>R21's progress notes dated 1/3/25 at 2:56 p.m., indicated an MDS review and was at high risk for falling with one fall with no injury since admission, poor safety awareness, impulsive, attempts to self-transfer out of bed and was moved closer to the nursing station and a night light was placed in R21's room.<br><br>R21's progress notes dated 1/20/25 at 6:24 a.m., indicated staff saw R21 on the floor and had apparently tried to get up by himself and fell .<br><br>R21's progress notes dated 1/20/25 at 8:45 p.m., indicated R21 was found on the floor in the bathroom between the sink and toilet and 911 was called.<br><br>R21's progress notes dated 1/21/25 at 4:16 p.m., indicated the nurse practitioner was updated earlier regarding R21's two falls. There was no other documentation on 1/21/25, regarding the falls in the progress notes.<br><br>R21's progress notes dated 1/25/25 at 9:59 a.m., indicated R21 was found sitting on the floor next to the bed with the head against the nightstand and was attempting to get back to bed from the wheelchair when R21 fell .<br><br>R21's progress notes dated 1/25/25 at 10:01 a.m., indicated the care plan was updated with new falls intervention to offer to help to lie down after meals when tired.<br><br>During interview on 1/27/25 at 5:25 p.m., family member (FM)-A stated R21 had three falls and went to the hospital for one of the falls.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During observation on 1/27/25 at 6:33 p.m., care plan indicated to assist to bed after meals and R21 was up in the chair.<br><br>During observation on 1/28/25 at 8:48 a.m., R21 was up in his wheelchair and appeared to be asleep at the nursing station.<br><br>During interview and observation on 1/28/25 at 1:29 p.m., nursing assistant (NA)- C stated they looked to the Kardex on the computer to know what cares a resident required. She added R21 fell all the time and now they locked the wheelchair next to the bed and lower the bed, tied the call light to the bed and stated sometimes closed the door to resident's room., She stated, R21 was at risk for falling and they were trying to find a low bed because R21's bed did not go all the way to the floor. NA-C verified R21 did not have a grabber and stated she thought the facility took it away because R21 was falling. NA-C verified no Kardex was hanging in the room.<br><br>During observation on 1/28/25 at 1:51 p.m., trained medication aid (TMA)-A shut R21's door and did not go inside the room. At 1:56 p.m., R21's door remained closed.<br><br>During interview and observation on 1/28/25 at 1:56 p.m., TMA-A stated they checked the care plan and residents at risk for falling had an arm band, needed the call light close and the bed needed to be down. TMA-A confirmed the door was closed and that she walked by and closed the door.<br><br>During observation on 1/28/25 at 2:12 p.m., staff set a new grabber on R21's bed side table.<br><br>During observation on 1/29/25 at 7:15 a.m., R21's call light was on the night table across but out of reach no grabber.<br><br>During interview on 1/29/25 at 8:42 a.m., director of nursing stated nursing assistants and nurses are expected to use the Kardex and for residents at risk for falls the Kardex should be posted in the resident's room. R21's door should be opened, the call light within reach, checked, and changed every couple hour, wheelchair locked and near bed. She confirmed that NA-C was told on 1/28/2025 to place a new grabber in R21's room and does not believe the grabbers work as this is an intervention implemented by therapy, not nursing. She is looking into a low bed for R21 and identified interventions that could be implemented in the care plan like increased time at activities, and stated R21 is just bored and restless.<br><br>R187:<br><br>R187's admission MDS in progress dated 1/26/25, indicated moderate cognitive impairment.<br><br>R187's Medical Diagnosis form indicated the following diagnoses: traumatic ischemia of muscle, cystitis, and chronic kidney disease stage 3.<br><br>R187's Nursing Admit Data Collection form, dated 1/22/2025 at 3:15 p.m., indicated the resident was admitted from the hospital for fall, traumatic, rhabdomyolysis. Physical and occupational therapy is recommended.<br><br>R187's Orders form indicated the following orders:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1/22/25, trazodone (an antidepressant) 50 mg tablet, give 0.5 tablet by mouth at bedtime for trouble sleeping.<br><br>1/22/25, buspirone (an anxiolytic) 10 mg tablet, give 1 tablet by mouth two times a day for major depressive disorder.<br><br>1/22/25, mirtazapine (an antidepressant) 30 mg tablet give 1 tablet by mouth at bedtime for major depressive disorder.<br><br>1/22/25, tramadol (an opioid) 25 mg tablet, give 0.5 tablet by mouth every 4 hours as needed for pain. Pain: 4-6. Must chart effectiveness and give 1 tablet by mouth every 4 hours as needed for pain. Pain: 7-10. Must chart effectiveness.<br><br>1/23/25, escitalopram oxalate (an antidepressant) oral tablet 5 mg give 1 tablet by mouth one time a day for major depressive disorder.<br><br>1/22/25, diphenhydramine hcl (an antihistamine) 50 mg capsule, give 1 capsule by mouth as needed for skin reaction if consuming shrimp. D/C Date 1/24/25<br><br>R187's Pharmacy New Admit Review was electronically sent to the DON, physician, and nurse practitioner on 1/23/25 at 7:08 p.m., indicated recommendations to update directions for diphenhydramine and lidocaine. The pharmacist recommended once R187 was settled consider decreasing the doses or discontinuing some of the five psychoactive medications prescribed. Noting she doesn't have any mental diagnoses under the tab.<br><br>R187's care plan dated 1/22/25, indicated R187 was on medications with an FDA black boxed warning or warnings of adverse consequences related to atrial fibrillation, migraine, depression, hypertension, pain, and trouble sleeping. Interventions included to refer to the boxed warnings in the orders or eMAR, or medication reference of choice for mirtazapine, escitalopram, tramadol, and trazodone.<br><br>R187's care plan dated 1/23/25, indicated R187 had an activity of daily living (ADL) deficit due to cystitis, fall, rhabdomyolysis and required limited assist of one staff with a walker and gait belt for ambulating short distances in the room. Further, R187 required limited assist to use the toilet and transferred with limited assist of one using a walker and gait belt.<br><br>R187's care plan revised 1/28/25, indicated R187 had actual falls due to rhabdomyolysis, history of traumatic brain injury, deconditioning, gait and balance problems, and a history of falls and had the following interventions: educate resident and family about safety reminders and what to do if a fall occurs, educate the resident, family, and IDT of the cause of the fall, educate and instruct the resident and family on the safe use of assistive devices, 1/28/25 keep the walker within reach, remind to cue resident to call for assistance, remind resident not to bend over to pick up dropped items, encourage use of grabber or to ask for assistance, modify the environment to maximize safety, call light should be in reach, 1/28/25 offer toileting assistance upon arising, before and after meals, bedtime and as needed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R187's Falls Tool form dated 1/22/25 at 6:28 p.m., indicated R187 had recent falls, took two or more risk factor meds such as sedatives, anti-depressants, anti-Parkinson's, diuretics, anti-hypertensives, hypnotics. Under the heading, Risk Factor-Psychological (Anxiety, Depression, Decreased Cooperation, Decreased Insight or Decreased Judgement especially related to mobility) indicated, Does not appear to have any of these. Further, the risk factor check list and intervention plan had check boxes that were checked for mobility and transfers, changes in mobility related to muscle weakness or strength, impaired balance or coordination, cognitive status, poor memory, medical problems included check boxes for changes in medication, high risk medications, changes in condition, and under the heading, Action Plan included check boxes to refer to therapy, restorative nursing, provider or practitioner, obtain a pharmacy consult, refer to the registered dietician, and update the care plan. The only box checked was to update the care plan.<br><br>R187's Fall Scene Huddle Worksheet dated 1/28/25, at 6:45 p.m., indicated anticoagulant, antidepressant, cardiovascular were given in the past eight hours. R187 was found on the floor, had attempted to ambulate and self-transferred, used walker and lost balance. Last toileted at 5:30 p.m. and complained of back pain with movement.<br><br>R187's Falls Tool form dated 1/28/25 at 8:56 p.m., and saved on 1/29/25 at 12:05 p.m., indicated there were no fall risk factors indicated, no risks factor checklists or interventions; no action plans were identified.<br><br>R187's dispatch health imaging final report dated 1/30/25 at 12:59 p.m., indicated thoracic spine two views, there are no prior examinations for comparison. There is diffuse bony demineralization and kyphosis. There is a compression deformity of a midthoracic vertebral body of uncertain age. This is probably T7. There is a diffuse degenerative disc disease throughout the thoracic spine. Compression, midthoracic vertebral body compression fracture of uncertain age. Fax was received at 1/30/25 at 12:16 p.m. and certified nurse practitioner notified 1/30/25 at 12:30 p.m.<br><br>R187's progress notes dated 1/22/25 at 5:38 p.m., indicated R187 had traumatic rhabdomyolysis of the right shoulder and arm and had not fallen prior to this one.<br><br>R187's progress notes dated 1/24/25 at 9:18 a.m., indicated R187 had a recent fall at home and<br><br>R187's PHQ-9 score was a 1 out of 27, indicating minimal depression.<br><br>R187's progress notes dated 1/27/25 at 8:43 p.m., indicated R187 forgot to take her medications at times and the assisted living facility set up R187's medications and R187 scored low on cognitive assessments.<br><br>R187's progress notes dated 1/29/25 at 9:18 a.m., indicated R187 had a fall and would get an x-ray. The notes lacked information when R187 fell , how R187 fell , what R187 was doing at the time of the fall, or any type of fall assessment.<br><br>R187's progress notes dated 1/29/25 at 12:54 p.m., indicated the nurse practitioner was updated<br><br>R187's son requested x-rays because R187 fell and had pain.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R187's progress notes dated 1/30/25 at 12:41 p.m., indicated the nurse practitioner was at the facility and reviewed the x ray results. No other information was documented.<br><br>R187's Potential Clinically Significant Medication Issues form dated 1/24/25 at 9:14 a.m., indicated a drug regimen review did not find issues of a potentially clinically significant medication issue. Additionally, check boxes indicating the date and time the prescriber was contacted was undocumented.<br><br>R187's Interim Medication Regimen Review dated 1/28/25 and signed by admitting physician indicated physician orders reviewed with high-risk monitoring recommendations for anticoagulant and tramadol.<br><br>R187's Risk Management Report from 1/28/25 at 9:20 p.m., stated the resident was found on the floor after trying to open the door. Assessed by registered nurse (RN)-A and recommended two certified nursing assistants to use the Hoyer lift to get R187 off the floor. Under the heading, Predisposing Situation Factors, not applicable was documented and no documentation of psychopharmacological medications. IDT reviewed incident on 1/29/2025.<br><br>R187's Mar/Tar indicated on 1/29/25 amlodipine was given for hypertension, escitalopram oxalate was given for major depressive disorder, lisinopril for hypertension, melatonin for insomnia, mirtazapine for major depressive disorder, trazadone HCL for sleep, buspirone twice for major depressive disorder, carvedilol twice for atrial fibrillation, divalproex sodium twice for migraine, apixaban twice for atrial fibrillation, acetaminophen once for pain, tramadol three times for pain.<br><br>R187's was referred to therapy due to a fall on 1/18/25 at home.<br><br>R187's occupational therapy (OT) report dated 1/23/25 through 2/21/25 indicated, a baseline assessment was completed on 1/23/25. R187 demonstrated good rehab potential as evidenced by ability to follow one-step directions, able to make needs known, active participation in skilled treatment, motivated to a participate, motivated to return to prior level of living, strong family support and supportive caregivers/staff. R187 was assessed for activities of daily living (ADL's) and needed substantial to maximal assistance for toileting hygiene, shower/bathe, putting on/taking off footwear. Set up assistance for eating and oral hygiene. Supervision for upper body dressing and partial assistance for lower body assistance. R187 transferred with supervision or touching assistance, ambulated 10 feet with touching assistance, toilet transferred with supervision or touching assistance, partial assistance with bed mobility. R187 was able to sit up unsupported for 30 seconds with feet flat on floor and no back support. Ability to communicate wants and needs. Followed one step directions. Modified decision making. Therapy noted, patient presents with impairments in balance, mobility, strength, follow through, planning and problem solving resulting in limitations and/or participations restrictions in the areas of general tasks and demands, mobility and selfcare which requires skilled OT services to maximize independence with ADLs to facilitate ability to live in environment with least amount of supervision and assistance. Due to the documented physical impairments and associated functional deficits, without skilled therapeutic interventions, the patient is at risk for falls and further decline in function. R187 attended OT on 1/23/25, 1/24/25, and 1/27/25. OT notes for 1/28/25 and 1/30/25 indicated resident was not able to participate in therapy due to fall on 1/28/25.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R187's physical therapy (PT) report dated 1/23/25 through 2/21/25 indicated resident demonstrates good rehab potential as evidenced by high prior level of functions, motivated to participate, motivated to return not prior level of living and stable medical condition. R187 attended PT on 1/23/25, 1/24/25 and 1/28/25. PT notes for 1/29/25 and 1/30/25 indicated resident was not able to participate in therapy due to fall on 1/28/25.<br><br>During observation on 1/27/25, at 2:28 p.m., no grabber or call light in reach.<br><br>During observation on 1/27/25 at 6:10 p.m., call light pressed for R187 to check response time. At 6:12 p.m. staff did not respond to call light but did deliver meal tray. At 6:14 p.m. through 6:17 p.m. the call light remained on in the resident's room, but the marquee in the hallway closest to the resident's room was not displaying room ten and had a black screen. However, the marque near the nursing station on the opposite end did have Room ten scrolling on the marquee.<br><br>During observation on 1/28/25 at 8:26 a.m., R187 was in her recliner, had vomited and attempted to use remote for lift chair to sit up. Call light was out of reach, assisted R187 with call light and she stated she was ready to go back to bed. Notified nursing assistant (NA)-D that resident vomited. The marquee near room ten was on.<br><br>During observation on 1/29/25 at 11:57 a.m., verified with nursing assistant (NA)-C there was no grabber in R187's room.<br><br>During an interview on 1/30/25 at 9:11 a.m., with registered nurse, (RN)-C, stated that she was not working at the time R187 fell , but neurological assessments are checked for three days following a fall.<br><br>During observation on 1/30/25 at 9:30 a.m., dispatch health imaging arrived for imaging. The nurse practitioner was notified at 1/30/25 at 12:30 p.m. of the results.<br><br>During an interview on 1/30/25 at 9:32 a.m., with registered nurse, (RN)-A, stated the floor nurse was on break when R187 fell . I assessed R187 and she was doing fine so the aids got her up using the lift. The fall assessment would be completed once the floor nurse returned from break. Verified with RN-A no progress note was entered regarding the initial fall assessment when R187 was on the floor. Licensed practical nurse (LPN)-B must have called R187's son because he is aware of the fall and inquired if this would change discharge planning.<br><br>During a phone interview on 1/30/25 at 11:00 a.m. with LPN-B, stated she works for Focus One agency and has been trained for falls at this facility. LPN-B was on break during the fall. RN-A assessed R187, and LPN-B contacted the family. LPN-B completed the fall scene huddle worksheet and falls management checklist. LPN-B confirmed that RN-A assessed R187. Vital signs were entered in the medical chart at 1/29/25 at 4:15 p.m. and again 1/30/25 7:12 a.m.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 1/30/25 at 12:31 p.m., pharmacist stated admission medications are reviewed within three days. If issues are identified the review will be completed immediately. The pharmacist looked for medication duplicates, same class of medications and any information that doesn't look right. The pharmacist stated, the current process is to email the DON, nurse practitioner and physician with recommendations. Red is used to identify a nursing task and black is used to identify a physician task. The nurse practitioner looked at medication orders and the DON looked for accuracy in the eMAR. This system has been used since he started reviewing at this facility. The pharmacist did review R187's medications and emailed the DON, nurse practitioner, and physician with recommendations on 1/23/25 at 7:08 p.m. The pharmacist stated in his email, she takes 5 psychoactive meds. I'm not sure if she was in the hospital for a fall because she has [NAME] appointments. Once she is settled, consider decreasing the doses or discontinuing some of them. She doesn't have any mental diagnoses under that tab. The pharmacist stated that taking all five of these psychoactive medications could have potential incompatibilities, fall risk, clarity issues and since she did not have a mental diagnosis the facility should review the medications and that was his recommendation.<br><br>During interview on 1/30/25 at 1:03 p.m., with the minimum data set (MDS) coordinator, registered nurse (RN)-D, stated she is aware of the process the pharmacist uses when reviewing new admission medications, but could not find an email forwarded by the DON, Nurse Practitioner, or Physician to her regarding the recommendations and was not on the original email sent by the pharmacist regarding R187's medication review. RN-D stated she usually receives gradual dose reductions (GDR's) from the pharmacist or DON. RN-A and the HUC will also work on transcribing orders, but confirmed an RN would always double check the HUC's work. RN-D verified that the MDS for R187 is not completed, but she did confirm she marked NO for assessments needed for medications and crossed off the NO during this interview. RN-D stated, the MDS system will flag the new file if there is a black box warning for medications or duplicate medications but isn't aware if the system will identify five drugs in the same class. RN-D agreed that in this case the pharmacist recommendations have not been completed.<br><br>During interview on 1/30/25 at 1:28 p.m., the DON stated the nurse practitioner did not respond back to the pharmacist email regarding the recommendations for R187's psychoactive medications. The expectation is that if it is a nursing error or fix, she will take care of it. RN-D could also make this change. The DON confirmed there is no system in place for duplicate or multi-class medications dispensed to residents and that nursing would have to use critical thinking skills for dispensed medications. The DON confirmed in this situation the floor nurses should have recognized that R187 was receiving five psychoactive medications in addition to identified as a fall risk. The DON stated what should have happened was the nurse practitioner reviews the discharge summaries from the hospital and if R187 was on medications prior to the hospitalization then these are considered home meds, and the provider will not change the order. The DON thinks R187 came to the facility on these medications, the review was sent to the pharmacist, and she is not sure what happened here. When asked what did happen, the DON said survey stress, documentation from the nurse that day should have been better and then the completed fall tool would have been reviewed earlier. The DON verified the nurse practitioner did sign off on the review from the pharmacist but did not make the recommended changes. At the next pharmacy review meeting the DON will suggest another layer of review to be added to this system.<br><br>During interview on 1/30/25 at 1:36 p.m., RN-A stated there is no treatment needed for R187's fall that occurred on 1/29/25. R187's injured back will need to heal itself and to talk to the DON for more information. At 1:38 p.m., the DON stated R187 sustained an L4 and mid thoracic compression fracture of uncertain aging.<br><br>(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<br>B. Wing | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Good Samaritan Society - Stillwater | 1119 Owens Street North<br>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.

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reviewed [NAME] Policy Falls Resource Packet Rehab/Skilled dated 5/7/24. |