STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Waconia and Westview Acre	333 Fifth Street West Waconia, MN 55387

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49035 Based on interview and document review, the facility failed to complete a thorough investigation for 2 of 3 residents (R5, R9) who reported concerns related to quality of care. Findings include: Facility investigation indicated the director of nursing (DON) was notified via email on 9/16/24 at 4:24 p.m., from administrative assistant (AA)-D the facility had two bad apples working there. The document included handwritten notes dated 9/18/24 at 11:50 a.m., listing licensed practical nurse (LPN)-B and nursing assistant (NA)-A had not completed nightly rounds and refused to complete requested cares stating the next shift could complete them. Further, the document indicated R5's name dated 9/18/24 at 12:10 p.m. Information listed included LPN-B and NA-A had laughed when he reported he had chest pain, had not followed up on the report with any assessment or monitoring, and they had spoke to him and other residents in a condescending or argumentative way. Facility investigation lacked evidence other residents and other staff were interviewed about the identified concerns. Facility schedules indicated LPN-B worked 9/17/24, 9/20/24, 9/22/24, 9/23/24, 9/24/24, 9/27/24, 9/28/24, 9/30/24 and NA-A worked 9/17/24, 9/18/24, 9/19/24, 9/20/24, 9/21/24, 9/22/24, 9/23/24, 9/24/24, 9/26/24, 9/27/24, 9/30/24. During an interview on 10/1/24 at 1:15 p.m., DON stated LPN-B and NA-A frequently worked the same shift on the same unit. She stated no changes to the schedule had been made since the report on 9/16/24. The DON stated she had not spoken with LPN-B or NA-A in person nor by phone 9/30/24. However, she had left messages requesting they speak with her. DON stated she had not attempted to speak with either staff at the facility during their scheduled shifts. Further, the DON had not spoken with any additional residents to inquire about quality of care received, nor other staff members to obtain reports on care provided by LPN-B or NA-A since the report filed on 9/16/24. The DON stated she spoke with human resources and was instructed to complete a written warning to put in LPN-B and NA-A's employee files. During an interview on 10/1/24 at 3:01 p.m., DON stated she had only spoken with R5 and R9 regarding cares received because R9 told her many residents were not cognitively intact and therefore could not report concerns. The DON again confirmed she had not reviewed charting or spoken with other residents or staff regarding concerns. The DON stated she had not followed up with either R5 nor R9 but planned to next week. The DON stated it had not occurred to her to interview other residents or staff as part of the investigation. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/1/24 at 3:32 p.m., facility administrator stated he expected any complaint from a resident regarding quality of care was followed up on as soon as possible. His expected time frame for as soon as possible was dependent on the complaint or concern brought forward.

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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	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 35992 Based on observation and interview, the facility failed to consistently administer medication in the time frame allotted (one hour before and after assigned time) for 1 of 2 residents, (R2), reviewed for receiving a combination medication used for treatment of Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). Findings include: R2's Admission Minimum Data Set (MDS) indicated R2 was cognitively intact and was able to communicate needs and identify preferences. The MDS identified R2 had a medically complex condition. R2's MDS identified medical diagnoses, which included arthritis due to other bacteria, sepsis (infection of the bloodstream) due to methicillin susceptible staphylococcus aureus (MRSA-a type of infection which is resistant to many antibiotics), a cerebrovascular accident (CVA-stroke), and Parkinson's disease. A review of R2's medication administration record for September of 2024 indicated R2 was to receive Sinemet (Carbidopa-Levodopa-a medication used in management of Parkinson's disease) five times a day. The time of medication administration identified on the medication record correlated with the times the medication had been administered to R2 in the hospital. During interview on 9/30/24, at 10:23 a.m. family member/friend (FM-A) identified concerns regarding the administration times of R2's medication. FM-A stated she had specific directions as to how the medications were to be taken, however, R2 had reported to FM-A the medications were not given within the allotted time frames. A review of the medication administration record (MAR) was completed for the month of September 2024, which identified medications were to be given at 8:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m. and 10:00 p.m The MAR did not identify the exact times the medications were administered. A request was made from the director of nursing (DON) for documentation to reflect actual time the medications were given. On 9/30/24, at approximately 1:00 p.m. the MAR information provided by the DON was received. A review of the MAR screen shots of the information identified nine instances in the dates provided from 9/5/24 through 9/17/24 when the time frame was greater than one hour before or after the designated time. The DON stated medications were to be given within one hour before, or after, the designated time to be considered within the required time frame. The DON stated medications were to be given within the time frame as ordered to assure proper spacing of the dosing, especially when the medication is ordered multiple times per day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/1/24, at 10:39 a.m., registered nurse (RN-A), clinical manager, stated upon admission, when a resident was receiving frequently dosed, time sensitive medicines, she reviewed the medical records from the hospital, or admitting organization, and interviewed the resident to assure this was the time the resident had previously taken the medication at home to assure it was given with the same spacing. RN-A stated medications were to be administered within one hour before, or after, the designated time to meet the time frame requirements. RN-A reviewed the times of actual medication administration time frame for the medication. The following concerns were identified with administration, as denoted by the dates: On 9/2/24, the 6:00 p.m. medication was given at 7:36 p.m (1 hour and 36 minutes beyond the time scheduled-36 minutes outside of the parameters of allowed medication administration time). On 9/3/24, the 8:00 a.m. medication was given at 9:44 a.m. (1 hour and 44 minutes beyond the time-44 minutes outside of the parameters of allowed medication administration time). On 9/4/24, the 8:00 a.m. medication was given at 9:29 a.m. (1 hour and 29 minutes beyond the time-29 minutes outside of the parameters of allowed medication administration time). On 9/5/24, the 6:00 p.m. medication was given at 7:06 p.m (1 hour and 6 minutes beyond the time-6 minutes outside of the parameters of of allowed medication administration time). On 9/6/24, the 12:00 p.m. medication was given at 13:08 p.m (1 hour and 8 minutes beyond the time-8 minutes outside of the parameters of allowed medication administration time). On 9/8/24, the 8:00 a.m. medication was given at 10:29 a.m. (2 hours and 29 minutes beyond the time-1 hour and 29 minutes outside of the allowed medication administration time). The previous dose had been given at 11:07 p.m. on 9/7/24 (this is a period of 11 hours and 22 minutes). The next dose of the day was given at 1:17 p.m. for the 12:00 p.m. dose. This is 17 minutes beyond the parameters allowed for medication administration. This was also a spacing of 2 hours and 48 minutes space, versus the 4 hours spacing scheduled. The subsequent dose was ordered for 3:00 p.m., and was administered at 2:47 p.m. This was a spacing of 1.5 hours instead of the 3 hours spacing scheduled. On 9/9/24, RN-A stated the dosing of medications were delayed related to R2 being in the ER, and medications were administered upon her return. On 9/11/24, the 8:00 a.m. medication was given at 9:36 a.m. (1 hour and 36 minutes beyond the time-36 minutes outside of the parameters of allowed medication administration time). On 9/12/24, the 8:00 a.m. medication was given at 9:21 a.m. (1 hour and 21 minutes beyond the time-21 minutes outside of the parameters of medication time). On 9/13/24, the 6:00 p.m. medication was set up 5:41 p.m., however was signed out at 7:41 p.m. (1 hour and 41 minutes beyond the time-41 minutes outside of of the allowed medication administration time). On 9/14/24, the 8:00 a.m. medication was given at 9:49 a.m. (1 hour and 49 minutes beyond the time-49 minutes outside of the parameters of of allowed medication administration time). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following the review of the times noted above, RN-A stated she noted the majority of the areas of concerns are related to the morning medication pass at 8:00 a.m RN-A stated R2 had identified upon admission she experienced increased stiffness and pain when her meds were not given in a timely fashion. RN-A stated one the primary concerns would be the potential side effects experienced related to not receiving her medications on time, especially because this was definitely a time sensitive medication. In addition to R2, RN-A identified other residents would be potentially impacted with this problem as well. RN-A stated timed pain medications, thyroid medications, anticoagulants, and medications given more than daily were the ones she was most concerned about. On 10/1/24, at 12:33 p.m. the consultant pharmacist (CP-A), was contacted regarding the delayed medication administration times. CP-A stated the medication had a short half-life (the time it takes a medication in your body for the active substance in a medication to reduce by half), and added the medication reached it's peak effectiveness in 30 minutes. CP-A stated delayed administration of this medications had the potential for the resident to experience side effects. The facility policy, Medication: Administration Including Scheduling, reviewed/revised 3/29/23, identified the purpose of the policy included administration of medications correctly and in a timely manner, as well as to schedule medications effectively. Upon review of the policy, under the section labeled Procedure, the staff were directed to: Administer medications within at least 60 minutes on each side of ordered time.