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	02/27/2025

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

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 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** 48300 Based on observation, interview, and document review, the facility failed to comprehensively assess wounds with measurements and consistently implement interventions to promote healing of current pressure ulcers (PU) for 1 of 3 residents (R3). Findings include: R3's quarterly Minimum Data Set, dated dated dated [DATE] indicated severe cognitive impairment, required substantial assistance with footwear, had one unhealed Stage 3 PU (full thickness loss of skin) and at risk for developing more, and did not exhibit rejection of care behaviors. R3's care plan dated 2/10/25, indicated R3 had a Stage 3 pressure ulcer to her left lateral (outer side) ankle with interventions included provide pressure reducing mattress and pressure reducing cushion in wheelchair, notify nurse immediately of any new areas of skin breakdown, R3 had an activities of daily living (ADL) performance deficit with interventions included resident requires assistance of one staff apply surgical shoe on right foot and shoe on left foot. R3's care plan lacks information about an off-loading boot to her left foot while she is in bed. R3's physician orders summary dated 2/26/24, instructed staff to apply heel boot to left foot at night and anytime when in bed during the day. Okay to remove when sitting in wheelchair. An additional provider order instructed wear a surgical shoe to right foot. R3's physician order summary also included an order to change dressing to left lateral ankle wound every other day. On 2/26/25 at 10:48 a.m., registered nurse (RN)-B was interviewed and stated when she observed R3 earlier in the morning, R3 was not wearing the pressure relieving boot and RN-B did not apply the boot. RN-B stated there was no order in R3's treatment administration record (TAR) to apply the boot during the day shift. RN-B confirmed the provider order instructed staff to apply the off-loading boot to R3's left foot anytime when in bed. RN-B stated the wound data assessment should be completed daily even if the resident's wound does not have a dressing change that day. The wound data assessment includes information about how the wound looks, drainage, measurements, and dressing information. RN-B stated she would not know whether the wound was healing or deteriorating, or the provider needed to be updated if the wound data assessment was not completed. RN-B would look at the user-defined assessments (UDA) list to know if an assessment needed to be completed during her shift. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/2025 at 3:05 p.m., nurse manager (NM)-A was interviewed and stated a wound data collection assessment should be completed with every dressing change or daily if the dressing change is two times a day. The RN wound assessment should be completed once a week by a registered nurse. A nurse would know to complete these assessments by looking at the UDA list. A nurse should be looking at this list every shift and completing the assessments scheduled for the day. An assessment will remain on the UDA list until it is completed, turning red if it was not completed on the scheduled shift. On 2/26/25 at 10:24 a.m., family member (FM)-A was interviewed and stated when she was visiting R3 the previous evening, R3 was lying in bed without the off-loading boot on. FM-A stated she did not think R3 had the ability to put the boot on or take it off by herself. On 2/26/2025 at 11:06 a.m., R3 was observed laying in her bed on her left side with right foot resting on top of her left foot. A blue, fabric boot with Velcro straps was visualized on a chair near the foot of the bed. She is wearing only socks on her feet. R3 was interviewed and stated she should have a soft blue boot on her foot but does not have it on. Sometimes she wears it in bed and other times she does not. R3 stated she cannot put the boot on by herself and would let the staff put the boot on if they offered. On 2/26/25 at 11:34 a.m., nursing assistant (NA)-C confirmed R3 was lying in bed wearing only socks on her feet. NA-C stated R3 should be wearing the black surgical shoe on her right foot while in bed, not the soft blue boot. On 2/26/2025 at 11:42 a.m., NA-D was interviewed and stated there was no information in the nursing assistant documentation for day shift or on R3's Kardex (a shortened version of the resident care plan utilized by nursing assistants) about wearing an off-loading boot on her left foot while in bed. NA-D stated nursing assistants should be looking at the Kardex before each shift. On 2/26/25 at 11:56 a.m., R3 was observed sitting in her wheelchair in the dining room wearing a black hard bottom shoe with Velcro on her right foot and a regular shoe on her left foot. NA-E was interviewed and stated R3 was to wear the black support shoe on her right foot when she was up and when she laid down for naps during the day but not at night. NA-E confirmed the black hard bottom shoe R3 was wearing was the support shoe. On 2/26/25 at 1:17 p.m., nurse practitioner (NP) was interviewed and stated R3 was to wear a pressure reducing boot on her left foot whenever she is in bed to aid in healing of the pressure ulcer on her left ankle and a surgical shoe with toe protector on her right foot whenever she is out of bed. NP also stated wounds should be monitored and documented on with every dressing change. The documentation is needed to verify the wound is healing. Risks of not following provider orders or not monitoring the wound include worsening of the wound or development of a new wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 11:50 a.m., the director of nursing (DON) was interviewed and stated a wound data collection assessment should be completed daily for pressure, stasis, and surgical wounds and contains information about the wound, skin around the wound, measurements, and dressing. The assessment should be completed daily. If there is no dressing change scheduled, the assessment can be completed by indicating if the dressing is intact and if any drainage is seen on the outside of the dressing. Measurement of the wound should occur every 7 days and is usually completed during in-house wound rounds or on resident bath day. The RN wound assessment should be completed weekly. It included an overall assessment of the wound and if the wound is improving or deteriorating. The RN used the assessment to determine if the provider needed to be updated. DON confirmed R3 should have had the wound data assessment completed daily and the RN wound assessment completed weekly, but they had not been completed in the last 2 months. DON stated an off-loading boot is usually a soft, foam boot that is worn when in bed. The boot takes pressure off the heel but allows the resident to reposition themselves easily. R3 should be wearing the boot to protect the pressure ulcer on her ankle and should be wearing it whenever she is in bed. The Wound and Pressure Ulcer Management policy dated 6/05/24 instructed promotion of healing, pain management and prevention of complications are extremely important, as well as accurate assessment and documentation.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48300 Based on observation, interview and document review, the facility failed to ensure ongoing, routine toenail care was provided to prevent potential foot-related complications for 1 of 3 residents (R1) reviewed who had long, unkept toenails. Findings include: R1's significant change minimum data set (MDS) dated [DATE] indicated intact cognition with diagnoses including multiple sclerosis and bilateral broken legs. R1's care plan dated 1/15/25 indicated R1 required assistance of one staff member for weekly bed baths. The care plan instructed weekly skin observation by licensed nurse and to keep fingernails short but did not address toenail care. R1's medical record was reviewed and lacked information on resident refusal of toenail care and any ongoing monitoring and/or treatments to ensure R1's toenails were cared for timely and on an ongoing basis to reduce her risk of foot-related complications secondary to long toenails. On 2/25/25 at 1:09 p.m., R1 was interviewed and stated staff clip her fingernails, but no one clipped her toenails. Her toenails were long, and they hurt her feet. R1 stated when she asks staff to clip them, she is told that staff will notify the podiatrist, but nothing gets done. On 2/25/25 at 1:16 p.m., registered nurse (RN)-A was interviewed and stated nursing assistants can clip fingernails and toenails unless the resident is diabetic or on a blood thinner, then a nurse needed to clip the nails. RN-A confirmed R1 was not a diabetic and was not taking blood thinners. RN-A stated there was not specific place in the electronic medical record (EMR) to document nails were clipped, but the nurse could write a nurses note. RN-A confirmed there were no recent nursing notes about R1's toenails being clipped or refusal of toenail trimming. On 2/25/25 at 2:02 p.m., nursing assistant (NA)-A was interviewed and stated clipping a resident's fingernails and toenails should be completed on bath day as needed. A nurse is required to clip the nails of a resident who is a diabetic, but a nursing assistant can clip the nails of all other residents. A nursing assistant could look at a resident's meal ticket to see if they were a diabetic or could ask a nurse. NA-A stated she did not know if there was a place in the EMR to document nail care. On 2/25/25 at 2:14 p.m., NA-B was interviewed and stated nursing assistants should complete nail on bath days for residents who are not diabetic. NA-B also stated she would look at a resident's meal ticket to see if they were a diabetic or could ask a nurse because the information was not on the Kardex (a shortened version of the resident care plan utilized by nursing assistants). NA-B confirmed there was nowhere for a nursing assistant to document nail care in the EMR. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 2:52 p.m., a health information management (HIM) specialist was interviewed and stated she kept the list of residents who were seen by in-house podiatry. She confirmed R1 was on the list of people to be seen by the podiatrist, but there was no date set yet for when the podiatrist would be at the facility. On 2/25/25 at 3:05 p.m., RN nurse manager (NM)-A was interviewed and stated nail care should be provided to residents on bath days. If nursing staff are unable to clip the resident's toenails, the nurse manager should be notified so an order to see podiatry can be obtained from the provider. A nurse could document nail care in the free text box of the skin assessment. If a resident refuses nail care, it should be documented in a nurse's note. NM-A confirmed R1 was not a diabetic, so the nursing assistants were allowed to trim her nails. On 2/25/25 at 3:40 p.m., R1 was observed laying in her bed. The toenails on her left foot were observed to be several millimeters in length and had uneven, jagged edges on the nail. Nail on the great toe is thickened but the nails on the other toes appear normal thickness. NM-A confirmed R1's nails were really long and stated, looks like we could clip a couple of those nails. On 2/26/25 at 1:17 p.m., nurse practitioner (NP)-A was interviewed and stated nursing staff should complete nail care. If nursing staff are unable to cut the toenails, an order to see podiatry should be obtained. The risks of long toenails include ingrown toenails, increased pain, and nails rubbing on other toes causing a wound. On 2/27/25 at 11:50 a.m., the director of nursing (DON) was interviewed and stated nail care should be completed by nursing assistants on bath days for residents who are not diabetic. Nurses complete skin assessments and nail care for diabetics. DON confirmed there is no place in the EMR to document nail care because it is expected as part of the bathing process. Resident refusal of any type of care should be documented in a nursing note. The Activities of Daily Living (ADL) policy dated 12/23/24, indicated any resident who is unable to carry out ADLs will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. ADLs include care of hair, hands, face, shaving, applying makeup, skin, nails, and oral care.

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F 0689 Level of Harm - Minimal harm or potential for 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** 48300 Based on observation, interview and document review the facility failed to perform a comprehensive assessment of falls to include identifying a root cause and also failed to implement appropriate interventions to reduce the risk of falls for 2 of 3 residents (R2 and R4) reviewed for falls. Findings include: R2's quarterly minimum data set (MDS) dated [DATE] indicated intact cognition, no falls since the previous assessment and diagnoses included dementia and chronic obstructive pulmonary disease. R2's care plan dated 2/4/25 indicated R2 was at risk for falls related to weakness and shortness of breath with interventions of educate/instruct resident and family on usage of assistive devices added 10/15/23, remind resident not to bend over to pick up dropped items, encourage use of grabber or to ask for assistance added 10/15/23, and ensure resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair added 10/15/23. The care plan also indicated R3 was independent with four wheeled walker for transfers and ambulation. R2's communication note dated 2/21/25 at 8:00 p.m., indicated R2 was found sitting on the floor by his recliner. Resident stated he was getting up from his recliner to go to the bathroom, lost his balance and slid down to the floor. R2 was able to move all extremities, denied pain, and was assisted back to his recliner by two staff and full mechanical lift. Vital signs were stable. Family member was notified, and floor manager and director of nursing (DON) will be updated. On 2/26/25, R2's electronic medical record lacked information about an immediate intervention put in place to prevent a subsequent fall. R4's significant change MDS dated [DATE] indicated intact cognition, no falls since the last assessment, and diagnoses included congestive heart failure and type 2 diabetes. R4's care plan dated 2/12/25 indicated R4 had an actual fall related to losing his balance reaching for remote initiated on 10/5/24. Interventions included to: 1) Keep door his open to check on resident as he does not always ask for help when needed added 8/29/24. 2) Educate/instruct resident to ask for assistance from staff when feeling unwell or weak added 10/7/24. 3) Remind R4 not to bend over to pick up dropped items or items out of his reach. The reacher device provided and resident demonstrated use. 4) Encourage use and remind R4 to ask for assistance added 10/7/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5) Ensure R4 was wearing appropriate footwear when ambulating or mobilizing in wheelchair added 2/21/24 6) Ensure correct bed height by marking bed frame or wall to top of mattress or headboard added 5/16/24. 7) Review resident's medical record for medications or combinations of medications that could predispose to falls/increase risk added 10/5/24. 8) Review the status of any medical conditions that predispose R4 to falls or that could increase the risk of injury from falls added 5/16/24. The care plan indicated R4 was resistive to care related to dignity evidenced by refusal of assistance with personal/perineal hygiene, transfer assistance, and toileting. R4's communication with provider note dated 2/18/25 indicated R4 was found on his bathroom floor with a skin tear on his left elbow. Nurse practitioner was updated and provided orders to update with any changes and try to keep R4 at the facility due to comfort care status. R4's communication with provider note dated 2/21/25 at 11:18 a.m., indicated consult to hospice agency as soon as possible due to mass obstructing airway. R4's risk management resident description of event dated 2/17/25 indicated R4 was trying to reach the brief, lost his balance, and fell . Immediate action taken was to put R4 back to bed and remind him to call for help if he wants to get out of bed. R4's health status note dated 2/21/25 at 1:43 p.m., indicated the interdisciplinary team (IDT) met to discuss resident catheter and fall on 2/17/24, reaching for brief. Interventions listed were remind resident to not reach for items, use call light and ask for help, and reacher device given for resident use. R4's care plan was reviewed and reflected current care needs. R4's incident note dated 2/24/25 at 12:40 a.m., indicated R4 transferred himself to the bathroom, fell , then used the call light in the bathroom to call for help. R4 was found lying on the floor on his left side. Vital signs were taken. R4 complained of pain in his left hip and could not move his leg. R4 was transferred to his bed and provider and family notified. R4 was sent to the hospital for evaluation. R4's risk management resident description of event dated 2/24/25 indicated R4 was trying to sit down on the toilet, lost his balance, and fell . R4's other progress note dated 2/24/25 at 2:04 p.m., indicated R4 had a left hip fracture. On 2/26/25 at 10:48 a.m., registered nurse (RN)-B stated after a fall, the nurse should complete a risk management and a falls huddle worksheet. The falls huddle worksheet has all the information about a fall with a place to draw a picture of how the resident looked when a staff member found them on the floor. The risk management and falls huddle worksheet should be completed before a nurse leaves the facility at the end of their shift. The falls huddle worksheet is given to the nurse manager or slid under the nurse manager's office door if they have left for the day. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 1:17 p.m., nurse practitioner (NP)-A stated after a resident falls, nursing home staff should try to figure out why the resident fell . What were they trying to do when they self-transferred? Were they sick or in the hospital recently and had gotten weak? Were they going to the toilet more than usual? An in-depth investigation should be completed on all falls with an intervention put in place that is appropriate to the resident and the fall. NP-A stated some interventions could include therapy assessments and treatment, assessment of how the resident transfers, assisting with toileting at a specific time, and more frequent checks. NP-A stated R4 did his own thing and did not accept much help from staff. On 2/26/25 at 2:41 p.m., nurse manager (NM)-B stated after a resident falls, the nurse should fill out the fall huddle worksheet and risk management including an immediate intervention put in place. The nurse and nurse manager start the fall huddle worksheet. Then it is given to the director of nursing (DON). The interdisciplinary team (IDT) reviews the fall huddle worksheet and risk management to try to figure out why the resident fell . The resident's current care plan and immediate fall intervention are reviewed for relevance. The immediate intervention is added to the resident care plan or a new intervention unique to the current fall is put in place if IDT determines something else is needed. NM-B stated she had not received the fall huddle worksheet for R2's fall on 2/21/24. On 2/26/25 at 4:46 p.m., RN-C stated after a resident falls, a risk management and a fall huddle worksheet should be completed before the end of the shift. RN-C confirmed she was the nurse working when R2 fell on [DATE]. RN-C stated her shift was very busy that night and did not have time to fill out the fall huddle worksheet. R2 did not have any injuries from the fall so staff assisted him back into his recliner. RN-C could not recall if an immediate intervention was put in place and confirmed she did not fill out the fall huddle worksheet. On 2/26/25 at 3:38 p.m., the director of nursing (DON) stated there is a falls check list with the falls huddle worksheet. A nurse should follow the check list after a resident fall. The nurse starts the falls huddle worksheet with information about the fall then gives it to the nurse manager who reviews the check list and interventions. The worksheet then goes to the DON and it is reviewed with IDT. IDT meets every Tuesday and reviews the fall note, risk management, and falls huddle worksheet for date and time of fall, what the resident was doing, how they were found, what intervention was put in place and is that intervention in the care plan. IDT reviews falls weekly for one month to monitor if the intervention is effective. A complete root cause investigation included reviewing risk management, fall huddle worksheet, fall risk assessment, previous health status notes and clinical monitoring to see if the resident had a change of condition. DON confirmed the falls huddle worksheet could not be located for R2's fall on 2/21/25 and there was no immediate intervention listed in the risk management or on R2's care plan. DON stated it was difficult to know what happened without the floor nurse information included in the fall huddle worksheet. DON confirmed the falls huddle worksheets could not be located for R4's falls on 2/17/25 and 2/24/25. DON stated IDT had reviewed R4's fall on 2/17/25 in an IDT meeting on 2/18/25 determined the root cause of the fall was R4 was reaching for his brief but did not know if R4 was reaching to pull up a brief he was wearing or if he was reaching for a clean brief to put on. IDT determined an appropriate intervention was education about utilizing his call light for assistance because R4 was cognitively intact. R4 was sent to the hospital following the fall on 2/24/25 and he returned the same day. R4's care plan had been reviewed to determine the care plan was being followed, but there was no immediate intervention put in place and a root cause investigation had not been started. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 4:12 p.m. the administrator stated determining the root cause of a fall would be difficult without the falls huddle worksheet. The Fall Prevention and Management policy dated 7/29/24, defines root cause analysis as a method for identifying the causes of a problem so that the best solutions can be identified and put into place. The policy instructs staff to complete a fall scene huddle worksheet following a resident fall then give the completed worksheet to the fall committee chair or designee and review and update the care plan with any new changes or new interventions. The Fall Committee Guidelines policy dated 6/17/25, instructs the interdisciplinary team to gather data from the fall huddle, trend fall events, review fall reports in Point Click Care (the electronic medical record) and review care plans and may add, modify or evaluate fall interventions. Root cause analysis data collected at the scene of the fall, analyzed and trended, can provide evidence-based, validated information to drive necessary changes.