STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Specialty Care Community	3815 West Broadway Avenue Robbinsdale, MN 55422

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44648 Based on interview and document review, the facility failed to report an allegation of staff to resident abuse to the state agency (SA) within two hours after the allegation was made for 1 of 3 residents (R2) reviewed for abuse when the facility reviewed a video taken by a family member. Findings include: R2's care plan dated 9/26/23, indicated he needed extensive help from two staff for bathing, bed mobility, transfers from bed to wheelchair and dressing, R2's care plan dated 9/29/23, indicated he had impaired cognition, dementia, and delirium. Staff were directed to ask him yes and no questions and introduce one thought at a time. R2's significant change Minimum Data Set (MDS) dated [DATE], indicated he had severe impaired cognition. He had dementia, encephalopathy (a condition causing confusion, memory loss, and personality changes), cancer, protein malnutrition, weight loss, anemia, and received hospice care. He took antipsychotic and antidepressant medication. R2's care plan dated 7/1/24, indicated he was resistant to care and could be combative. Recommendations included talking calmly, explaining each tasks step by step, and if the behavior continued to leave him in a safe position and reapproach later. Also have another staff member attempt to provide care. R2's care plan dated 7/10/24, indicated he needed to have two staff provide care when able. On 7/17/24 at 11:25 a.m. family members (FM)-A video with audio was reviewed with the director of nursing (DON). The video was in five or six small clips. Some of the footage was blurry. The video showed the following: 1. NA-B walked into the room without introducing herself or telling R2 what she was going to do. 2. She pulled his blanket to the end of the bed exposing his body. She placed her right hand on his left hip and pushed him on to his side. She then pulled the brief out causing his body to be lifted off the bed until the brief came free. She then showed him the brief and said, see it's dirty. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. NA-B left R2 naked on the bed without covering him or lowering the bed to a safe level before she went into the bathroom. While she was gone R2 attempted to get out of bed. 4. R2 was kicking NA-B while she attempted to put his pants on. When she pulled the pants up, his whole body lifted off the bed. NA-B asked R2 several times why are you hurting me? NA-B grabbed onto his pants to pull and pushed R2 to get R2 to a transfer position to his wheelchair. 5. NA-B moved him from the bed to the wheelchair holding the resident's pants, not using a gait belt (thick belt placed on the resident's waist for staff to hold onto when transferring a resident from bed to wheelchair). During the transfer R2 was combative and she plopped R2 into the wheelchair causing the chair to jerk backwards. 6. NA-B tried to put on R2's shirt while he resisted her causing the shirt to get stuck over his face. A nurse walked into the room and helped him get the shirt off. NA-B told the nurse R2 would not let her get him dressed and was hurting her. The next videos were blurry and unable to see what happened next. During interview on 7/17/24 at 11:00 a.m. director of nursing (DON) stated on 7/8/24, R2's family member (FM)-A showed her a video of AP taking care of R2. The DON stated she felt the AP made mistakes such as continuing to dress him when he resisted her, and not using dementia care tactics. She could have asked for help or come back later. She also grabbed his clothing to turn him from side to side. She left him with the bed raised up to an unsafe level while she collected supplies in the bathroom and transferred him without a gait belt. While AP made mistakes, she felt the AP did not act with intent therefore she did not have to report the incident to the SA within two hours from watching the video. She suspended AP while doing an investigation of the events. She had AP review the video and explained to her what she did wrong, and what she could have done better. The AP did not comment on her actions. AP was terminated because the incident was her third and final warning. She said the other two warnings were not associated with resident care issues. During interview on 7/16/24 at 11:47 a.m. NA-A stated she received abuse training annually and after any incident of abuse. NA-A identified if she observed another staff member being abusive or rough with a resident, she would stay with the resident then report it to the nurse. She had abuse training a few weeks ago and education related to what to do if a resident is resistant to cares and hitting staff. She learned if a resident resisted care use a calm voice, be kind, and speak slowly. Facility policy Abuse & Neglect-Rehab/Skilled, Therapy & Rehab dated 7/6/23, indicated if an alleged abuse, neglect, mistreatment occurred, the facility was required to report to the State Agency within 2 hours after learning about the incident.