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	12/06/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to treat with dignity for 1 of 3 residents (R7) reviewed for resident rights. A nursing assistant (NA)-C was observed speaking to R7 in a belittling manner while providing cares. Findings include: R7's significant change Minimum Data Set (MDS) dated [DATE] indicated R7 had unclear speech, slurred or mumbled words. R7 could usually make himself understood. R7 did not have difficulty understanding others. R7's Brief Inventory of Mental Status (BIMs) of three indicating R7 was severely cognitively impaired. R7 was totally dependent on staff for eating, oral hygiene, toileting hygiene, showers, and dressing. R7 required extensive assistance with rolling left and right sitting to lying and sit to stand transfers. R7 was always incontinent of bowel and urine. R7's pertinent diagnoses were Huntington's disease (an inherited disease where the nerve cells in the brain break down), dysphagia (difficulty swallowing foods), and dorsalgia (back pain). Upon observation and interview on 12/6/24 at 11:40 a.m. nursing assistant (NA)-C went into R7's room to check on him. R7 was seated in his wheelchair reclined with his pommel restraint in place (a wheelchair cushion with a raised center section that keep the knees apart). NA-C walked in the room and said, What the hell? She noticed surveyor was observing and stated she was talking about the soap opera on his television on how in the hell the actors look like they did [AGE] years ago. NA-C asked R7 if he wanted to lay down. He shook his head and stated yes. She assisted him to his bed. His arms and legs were flailing when he was on his back in his bed. NA-C looked at surveyor and stated look how difficult he was to take care of with his movements. NA-C noticed R7's incontinence brief was wet along with the shorts he was wearing. NA-C placed clean shorts on him while he was on the bed. She was unable to change his brief on his bed due to his movements. NA-C told R7 she would have to take him in the bathroom to change his brief, he nodded yes. She stood him up, sat him down in his wheelchair, wheeled him to the bathroom, stood him up by the toilet so he could hold onto handrails. NA-C pulled R7's shorts down and removed his brief at which point he passed gas. NA-C in a harsh tone said seriously and used his name. NA-C cleaned him with a wet wipe and placed a clean brief on him and sat him back in his chair. When asked her about her comments after he passed gas NA-C stated she was just joking around with him, and he knew that. (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: 245279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER: Good Samaritan Society - Specialty Care Community		STREET ADDRESS, CITY, STATE, ZIP CODE: 3815 West Broadway Avenue Robbinsdale, MN 55422	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 12/6/24 at 11:46 a.m. R7 was asked using yes and no questions during the interview due to his aphasia (inability to communicate due to Huntington's disease) if NA-C was rough with him during the transfer process and he said no. R7 was asked if he thought NA-C spoke kindly to him and he stated No and then said I can't help how I am. R7 was asked if he felt that what NA-C said was verbal abuse and he stated yes. Upon interview on 12/6/24 at 2:54 p.m. the director of nursing (DON) stated she spoke with NA-C was told by NA-C that she was just joking around with R7. The DON provided immediate education to NA-C regarding treatment of residents and appropriate communication. The DON stated registered nurse, (RN)-C, spoke with R7 and R7 had no concerns about NA-C providing care to him. Upon interview on 12/6/24 at 3:09 p.m. RN-C stated she spoke with R7, and he told her he was not uncomfortable with NA-C's comments, and he was comfortable working with her. A policy regarding dignity was not obtained.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview and record review, the facility failed to ensure call lights, or another means to request assistance were accessible for 4 of 4 residents (R5, R6, R7, and R8) reviewed who were dependent on staff for mobility. Findings include: R5's care plan revision date of 10/23/24 indicated to keep call light and television remote in place especially when R5 was in bed due to falls. R5's quarterly Minimum Data Set (MDS) dated [DATE] indicated R5 had a Brief Inventory of Mental Status of zero indicating severe cognitive impairment. R5 was totally dependent on staff for eating, oral and toileting hygiene, dressing and transferring. R5 was always incontinent of bowel and bladder. R5's pertinent diagnosis was Huntington's disease (an inherited disease in which nerve cells break down over time.) R5 had falls in the facility. Upon continuous observation on 12/6/24 at 9:14 a.m. R5 completed breakfast at 9:20 a.m. R5 was taken to her room by NA-C. R5 was in her Broda wheelchair (a medical device chair that provides comfort and support) with truck restraints (a padded cushion with a belt secured between the thighs of a patient in the Broda chair) on her lower extremities. R5 did not have a call light in place, the light was hanging on the wall. R5 was checked at 11:37 a.m. when NA-C checked on R5 and asked her if she wanted to lay down. R5 said no. NA-C left the room without placing the call light within R5's reach. R6's MDS dated [DATE] indicated R6 had a BIMS score of 11 indicating cognitive impairment. R6 was dependent upon staff for oral and toileting hygiene, dressing and transferring. R6 was always incontinent of bowel and bladder. R6's pertinent diagnosis was Huntington's disease. R6's care plan dated 10/26/24 did not indicate the use of a call light or how R6 was to notify staff when assistance was needed. Upon continuous observation on 12/6/24 at 9:29 a.m. R6 was taken to her room by TMA-A. R6 was in her wheelchair in a reclined position with a pommel cushion (a wheelchair cushion with a raised center section that keeps the knees apart) in place. R6's call light was laying on top of her bed. At 10:34 a Hospice nursing assistant (NA)-D came to visit and provide cares. A hospice Registered nurse (RN)-F visited R6 at 11:30 a. m. and seated R6 at her lunch table in the commons area. Facility staff had not checked on R6 since leaving her in her room at 9:29 a.m. without her call light in place. R7's significant change (MDS) dated [DATE] indicated R7's Brief Inventory of Mental Status (BIMs) of 3 indicating R7 was severely cognitively impaired. R7 was totally dependent on staff for eating, oral hygiene, toileting hygiene, showers, and dressing. R7 required extensive assistance with rolling left and right sitting to lying and sit to stand transfers. R7 was always incontinent of bowel and bladder. R7's pertinent diagnose was Huntington's disease. R7's care plan dated 8/14/24 did not indicate the use of a call light or how R7 was to notify staff when assistance was needed. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon continuous observation on 12/6/24 at 9:31 a.m. NA-C took R7 to his room. R7 was in a reclined wheelchair with a pommel cushion between his legs. R7 was placed next to his bed facing his television. R7's call light was hanging on his wall. R7 was not checked on again until 11:40 a.m. when NA-C went into his room and changed his incontinent brief. NA-C left his room at 11:44 leaving him in his chair without his call light within reach. R8's care plan dated 8/14/24 did not indicate the use of a call light or how R5 was to notify staff when he needed assistance, or another means to notify staff when assistance was needed. R8's quarterly MDS dated [DATE] indicated R8 had a BIMs score of 11 indicating moderate cognitive impairment. R8 was always incontinent of bowel and bladder. R8 required moderate assistance of staff for activities of daily living and transferring. Upon continuous observation on 12/6/24 at 9:36 R8 was in his room with the door closed. R8 was in a wheelchair asleep approximately 10 feet from his bed. His call light was on the floor next to his bed. At 9:36 a.m. TMA-A checked on R8 and was heard saying to a nursing assistant that R8 was still asleep he will get breakfast later. Call light was still on the floor and R8 had not moved in his wheelchair. At 10:31 a.m. TMA-A had again checked on R8, and he was still asleep in his wheelchair in the same position. The call was placed on the bed as the bed was made. R8 was still in his room at 11:50 when the surveyor left the unit. Upon interview and observation on 12/6/24 at 11:35 a.m. NA-C stated that none of the residents can use the call light on the unit. She stated that is why they are checked on every two hours. She then stood up from the desk and went and checked on R5. Upon interview on 12/6/24 at 2:15 p.m. trained medication assistant (TMA)-A stated R5, R6, R7 and R8 are all able to use their call lights, however they do not use them that is why staff forget to place the call lights within reach. He was not certain if call lights were on the care plans. TMA-A stated all the residents are checked on every two hours. Upon interview on 12/6/24 at 2:26 p.m. RN-G stated R5 is not able to use a call light, her hands cannot function well enough to do so. R5 was supposed to be in the common area and not left alone in her room as she has tipped herself over in her wheelchair chair. R6 can use the call light as RN-G has seen her use it. R7 could use the call light if it were placed with him when he is seated in his chair in his room. R8 was able to use his call light. Upon interview on 12/6/24 at 2:52 p.m. the director of nursing, DON stated call lights are a standard of practice and are not on the care plan and they should always be in reach for the resident's use. The DON was not certain if R5, R6, R7, or R8 were able to use the call light. She stated staff are to check on the residents frequently. She did not clarify how frequent, stating depending on the resident. A facility policy titled Call Light with a revision date of 7/29/24 indicated the purpose was to ensure resident always had a method of calling for assistance. Staff was to place the call light within easy reach of the resident when leaving the room. For residents who are unable to use a call light, care plan appropriate interventions and provide adequate call light if applicable.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to complete a proper assessment, care planning, and ongoing re-evaluation for the use of physical restraints for 5 of 5 residents (R4, R5, R6, R7, and R8) reviewed to ensure the imposed restraint were used to treat the resident's medical symptoms, is not used for convenience or discipline, is the least restrictive alternative for the least amount of time and document ongoing re-evaluation for the need of restraints. Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE] indicated R4's Brief Inventory of Mental Status (BIMs) score of 1 indicated severe cognitive impairment. R4 required maximum assistance with personal hygiene, transferring and dressing. R4's pertinent diagnoses were Alzheimer's disease, adult failure to thrive (a syndrome in older adults characterized by unexplained weight loss, poor nutrition, inactivity and a decline in physical and mental functioning, pulmonary fibrosis (a lung disease which causes scarring making it difficult to breathe), and hallucinations. R4's physician order dated 10/25/24 indicated R4 used a Broda chair (a specialized wheelchair) with a back latching belt as needed for episodes of increased instability and confusion related to delusions/hallucinations. Staff was to document when using the restraint and document interventions attempted prior to use of the restraint (assist to rest in lounge chair, assist to sit with a snack, offer to lay down). Staff was to assess the need for thigh strap every 30 minutes and release every two hours to offload and reposition R4. R4's care plan dated 11/5/2020 - 12/6/24 indicated R4 used a back latching seat belt on a Broda chair, however the care plan did not identify the belt as a restraint and did not provide interventions for freedom of movement from the restraint following the orders to assessed need every 30 minutes and release every two hours. R4's care plan revision date of 7/14/21 indicated R4 was at risk for falls and had a history of falls related to mental distress, anxiousness and dementia, hallucinations, visuospatial deficient, anxiety, psychosis, altered balance, impaired judgement and incite of safety needs, has history of laying on the floor wandering dystonia, inability to sleep or rest, participate in daily routine, self-injurious behavior, physical ability decline and increased mental distress. R4's interventions were the use of a Broda chair with back latching seat belt as need for periods of increased stability, balance, confusion, delusion/hallucinated objections such as objects on the floor. When increased alertness, resident is able to walk without assistance or device. These interventions related to R4's falls, not the use of the restraint. R4's care plan revision date of 12/12/22 indicated R4 had the potential for pressure ulcer development related to dementia, fluctuation in physical mobility, at times need for Broad chair and rear latching thigh straps, incontinence, and history of ulcer. R4's goal was to have intact skin free of redness, blisters, or discoloration. R4's interviews were to reposition/offload every two hours when in Broda chair. These interventions were related to pressure injuries not the use of the restraints. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's Physical Device and/or restraint evaluation and review dated 11/27/24 indicated R4 had a specialty wheelchair and a lap/seat belt. The review indicated education was provided with the family of the Broda chair and belt. The chair with back latching seat was used as needed for periods of increased instability, poor balance, confusion, delusion/hallucination that put resident at risk of falls and injury. When increased alertness and mobility resident is about to walk independently without device. Resident tolerates Broda chair well, does not seem agitated by it. Is able to independently mobilize himself in Broda. Allows resident to rest/mobile safely. Alternatives of decreased stimuli, individual behavior management, medication and clinical review and relaxation techniques were applied. The evaluation did not provide any documentation of interventions for resident to have freedom of movement from the restraints matching the providers orders. R5's physician orders dated 2/3/21 indicated R5 had a Broda chair with a pommel cushion. No interventions for freedom of movement or the medical symptoms intended to treat were provided in the orders. R5's care plan revision date of 8/2/24 indicated R5 was to be up in Broda chair with back latching bilateral thigh belt positioning device. R5 was to be offloaded and repositioning of the thigh belt every two hours. Staff to assist to propel Broda chair. R5's quarterly Minimum Data Set (MDS) dated [DATE] indicated R5 had a Brief Inventory of Mental Status of zero indicating severe cognitive impairment. R5 was totally dependent on staff for eating, oral and toileting hygiene, dressing and transferring. R5 was always incontinent of bowel and bladder. R5's pertinent diagnosis was Huntington's disease (an inherited disease in which nerve cells break down over time.) R5 had falls in the facility. Upon observation on 12/6/24 at 9:04 a.m. R5 had a thigh belt restraint, not a pommel cushion as the physician orders indicated. R6's signed physician orders dated 10/5/24 -11/5/24 did not indicate R6 used a Broda chair with a pommel cushion, interventions for freedom of movement or symptoms the restraint was intended to treat. R6's Physical Device and/or restraint evaluation and review dated 10/19/24 indicated R6 had a soft helmet. R6's interventions were to release the soft helmet every two hours to offload and reposition. The evaluation did not mention the Broda chair with the pommel cushion. Upon observation on 12/6/24 at 9:04 a.m. R6 was seated in a reclined Broda chair with a pommel cushion between her legs. R7's signed physician order dated 10/5/24 - 11/5/24 did not indicate R7 used a Broad chair with a pommel cushion, interventions for freedom of movement or symptoms the restraint was intended to treat. Upon observation on 12/6/24 at 9:04 a.m. R7 was seated in a reclining Broda chair with a pommel cushion between his legs. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's Physical Device and/or Restraint evaluation and review dated 9/30/24 indicated R7 had high-low bed, mattress on the floor and a specialty wheelchair (Broda). Informed consent was obtained, however the name of the person who gave informed consent was left blank. Alternative attempts were to decrease stimuli, physical therapy/occupation therapy, and redirecting. The evaluation did not indicate the devices were a restraint. R7's pommel cushion was not addressed on the evaluation. No interventions were completed and there was no documentation of family/resident education documented. R7's care plan revised date of 12/5/24 indicated Hospice and Occupational therapy were to assist with proper positioning, chair height. Broda chair with pommel cushion for safety. Assist to proper height. Redirect to Broda as able. Trial of the new wheelchair date of 1/2023, consult with hospice. The care plan did not indicate any results or new interventions following the trial from 1/2023. The care plan did not identify any interventions for freedom or movement. R8's care plan revision date of 4/12/23 indicated R8 had a Broda chair with pressure redistribution cushion and self-releasing front latching seat belt. R8's care plan did not indicate interventions for freedom of movement or the symptoms the restraints were indented to treat. R8's signed physician orders dated 10/5/24 - 11/5/24 indicated R8 used a latching seat belt when he was up in his Broda chair. The orders did not indicate interventions for freedom of movement or the medical symptoms the restraint intended to treat. Upon interview on 12/5/24 at 11:48 a.m. the facility Medical Director stated the facility identified during the survey process that they did not have orders for some residents with restraints and he provided those residents with the orders required. The residents he provided orders for during the survey process were not identified. The Medical Director stated he was aware that assessments, education, consent, least restrictive method, and reassessments are required for restraint use and most of the residents with Huntington's disease used the restraints for repositioning. Upon interview on 12/5/24 at 1:12 p.m. registered nurse (RN)-C stated the residents should be assessed every 30 minutes to see if they still require the use of the restraint if the restraint is being used for behaviors. RN-C stated she was aware there needed to be a reason for the restraint documented, the care plan must have interventions to when to apply or remove the restraint. She was not aware there needed to be a signed physician orders along with facility documentation of what symptoms the restraints were used to treat. Upon interview on 12/6/24 at 2:26 p.m. RN-G stated the staff were to check on the residents with restraints every two hours and staff is to document the restraint checks. RN-G stated R4, R5, R6, and R7 could not remove their restraints themselves. She was not certain if R8 could remove his lap belt himself. Upon interview on 12/6/24 at 2:54 p.m. the director of nursing stated she is officially the infection preventionist and is filling for the DON for a leave, so she was not certain exactly how the facility monitors to make sure the care plans, orders and assessments have all of the required criteria for restraints. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled physical restraints/psychotropic medications alternatives dated 4/2/24 identified alternatives to use for physical restraints or psychotropic medications including environmental, physical, equipment and psychosocial. The policy indicated the risks to residents when a physical restraint is used: falls, accidental death, functional decline, skin breakdown, depression, decreased self-esteem, loss of control, anger, increased agitation, reduced appetite, decreased quality of life, power issues, family stress, loss of dignity, reduced bone mass, loss of muscle tone, strangling, suffocation, bruising, cuts scrapes, feeling of isolation and entrapment. The facility provided a bed assessment and side rail safety, focused audit with a revision date of 9/17/24. The policy was not specific to the use of restraints.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to implement the person-centered care plan for 2 of 4 residents (R5 and R7) reviewed to meet the resident's needs. In addition, the facility failed to complete a person-centered care plan for 2 of 4 residents (R4 and R6) to describe the residents medical needs. Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE] indicated R4's Brief Inventory of Mental Status (BIMs) score of 1 indicated severe cognitive impairment. R4 required maximum assistance with personal hygiene, transferring and dressing. R4's pertinent diagnoses were Alzheimer's disease, adult failure to thrive (a syndrome in older adults characterized by unexplained weight loss, poor nutrition, inactivity and a decline in physical and mental functioning, pulmonary fibrosis (a lung disease which causes scarring making it difficult to breathe), and hallucinations. R4's physician order dated 10/25/24 indicated R4 used a Broda chair (a medical device chair that provides comfort and support) with back latching belt as needed for episodes of increased instability and confusion related to delusions/hallucinations. Staff was to document when using the restraint and document interventions document interventions attempted prior to use of the restraint (assist to rest in lounge chair, assist to sit with a snack, offer to lay down). Assess need for thigh strap every 30 minutes and release every two hours to offload and reposition R4. R4's care plan dated 11/5/2020 - 12/6/24 did not indicate R4 was to be assessed every 30 minutes for the thigh strap and release every two hours to offload and reposition. R5's care plan intervention revision date of 12/12/23 indicated R5 was unsafe to use the toilet, staff was to check and change her incontinent brief every two hours and assist with bowel movements as needed. R5's care plan intervention revision date of 8/2/24 indicated R5 was to be up in Broda chair with back latching bilateral thigh belt positioning device. Offload and reposition thigh belt every two hours. Staff was to assist R5 to propel Broda chair. R5's care plan intervention dated 7/24/24 indicated R5 was to be turned/repositioned every two hours due to potential for pressure ulcers related to incontinence. R5's care plan dated 9/19/24 indicated R5 was to be kept in the common area as resident allows when up in her Broda chair due to falls. R5's quarterly Minimum Data Set (MDS) dated [DATE] indicated R5 had a Brief Inventory of Mental Status of zero indicating severe cognitive impairment. R5 was totally dependent on staff for eating, oral and toileting hygiene, dressing and transferring. R5 was always incontinent of bowel and bladder. R5's pertinent diagnosis was Huntington's disease (an inherited disease in which nerve cells break down over time.) R5 had falls in the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon continuous observation on 12/6/24 at 8:41 a.m. R5 was seated in her Broda chair with the trunk restrain buckled over her thighs. R5 completed breakfast at 9:20 a.m. R5 was taken to her room by NA-C. R5 was in her Broda wheelchair with truck restraints (a padded cushion with a belt secured between the thighs of a patient in the Broda chair) on her lower extremities. R5 was not checked until 11:37 a.m. when NA-C checked on R5 and asked her if she want to lay down, R5 was still in her Broda chair with her trunk restraints on. R5 was not repositioned, her incontinent brief was not checked or changed, and was not asked if she wanted to be in her room or in the common areas indicated for safety as her care plan indicated. R6's Physical Device and/or restraint evaluation and review dated 10/19/24 indicated R6 had a soft helmet. R6's interventions were to release the soft helmet every two hours to offload and reposition. The evaluation did not indicate any interventions for the Broda chair reclined with the pommel cushion (a wheelchair cushion with a raised center section that keeps the knees apart), which R6 was using. R6's MDS dated [DATE] indicated R6 had a BIMS score of 11 indicating cognitive impairment. R6 was dependent upon staff for oral and toileting hygiene, dressing and transferring. R6 was always incontinent of bowel and bladder. Upon continuous observation R6 was taken to her room by TMA-A at 9:29 a.m. R6 was in her wheelchair in a reclined position with a pommel cushion (a wheelchair cushion with a raised center section that keeps the knees apart) in place. R6's call light was laying on top of her bed. At 10:34 a Hospice nursing assistant (NA)-D came to visit and provide cares for R6. A hospice Registered nurse (RN)-F visited R6 at 11:30 a.m. and seated R6 at her lunch table in the commons area. Facility staff had not checked on R6 since leaving her in her room at 9:29 a.m. R6 was not checked on as her care by facility staff every two hours as indicated. R7's significant change (MDS) dated [DATE] indicated R7's Brief Inventory of Mental Status (BIMs) of 3 indicating R7 was severely cognitively impaired. R7 was totally dependent on staff for eating, oral hygiene, toileting hygiene, showers, and dressing. R7 required extensive assistance with rolling left and right sitting to lying and sit to stand transfers. R7 was always incontinent of bowel and bladder. R7's pertinent diagnose was Huntington's disease. R7's care plan with a revision date of 6/13/24 indicated R7 was to remind/assist to turn and reposition every two hours. Encourage R7 to lay down after means due to history of stage two pressure ulcers on buttocks. R7's care plan with a revision date of 9/20/24 indicated R7's incontinent brief was to be checked and changed every two hours and as needed. Staff was to apply barrier cream at least once per shift due to pressure ulcers. Upon continuous observation on 12/6/24 at 8:41 a.m. R7 was seated in his Broda chair with his pommel cushion between his legs. At 9:31 a.m. NA-C took R7 to his room. R7 was still seated in his reclined wheelchair with a pommel cushion between his legs. R7 was placed next to his bed facing his television. R7 was not checked on again until 11:40 a.m. when NA-C went into his room and changed his incontinent brief by laying him on his bed for a few minutes and then standing him by the toilet to change the pad. He was then sat back in the Broda with the pommel at 11:46 a.m. R7 was not offered a position change or asked if he wanted to lay down until 11:40 a.m. (continued on next page)

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	245279	A. Building B. Wing	12/06/2024

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8's care plan dated 7/28/11 - 12/5/24 did not indicate R8 had a Broda chair with a front latching seat belt or any parameters or interventions for the use. R8's quarterly MDS dated [DATE] indicated R8 had a BIMs score of 11 indicating moderate cognitive impairment. R8 was always incontinent of bowel and bladder. R8 required moderate assistance of staff for activities of daily living and transferring. Upon observation on 12/5/24 at 2:50 p.m. R8 was observed in a Broda chair with a front latching seat belt. Upon interview on 12/6/24 at 11:36 a.m. nursing assistant (NA)-C stated she did not ask R7 if he wanted to lay down after breakfast because he never stays in bed and his care plan should not say that. Upon interview on 12/6/24 at 2:52 p.m. the director of nursing (DON) stated her expectation is that the care is followed and is person-centered to and up to date. A facility policy titled Care Plans with a revision date of 12/2/24 indicated the comprehensive care plan includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interviews, and record review the facility failed to provide 1 of 3 residents (R3) reviewed who was unable to carry out activities of daily living (ADL's) the necessary services to maintain proper personal hygiene. Findings include: A facility grievance log dated 8/23/24 indicated R3 had complaints regarding cares indicating a resolution date of 9/12/24. No further documentation was provided upon request. A facility grievance log dated 10/8/24 indicated R3 had complaints regarding cares with a resolution date of 10/28/24. No further documentation was provided upon request. R3's physician orders dated 10/22/24 indicated to keep peri area clean and dry every shift. R3's hospital discharge summary dated 11/10/24 indicated R3 was septic due to catheter related urinary tract infection. R3 was discharged back to the facility on [DATE]. R3's care plan revision dated 11/15/24 indicated R3 had an ADL self-care performance deficit related to central cord syndrome at C5 (spinal cord injury which the spinal cords ability to transmit messages from the brain), post-traumatic stress disorder, gastric bypass for obesity, fibromyalgia (body pain and tiredness), sepsis due to catheter related urinary tract infections, cough with atelectasis (collapse of part of the lung), and fatigue needs assistance with ADLs. R3's goals were to improve current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene. Interventions were: Personal hygiene resident required one staff maximum assist. Two staff as able for perineal care. Toilet use resident required two staff maximum assistance check and change every two hours. Catheter care by nursing assistant twice daily. R3's re-admission MDS dated [DATE] indicated R3's BIMs score was a 15 indicating R3 was cognitively intact. R3's was assessed and did not have any behaviors or rejection of cares. R3 was totally dependent on staff for toileting hygiene and lower body dressing. R3 required extensive assistance with transferring, rolling left and right, and upper body dressing. R3 had an indwelling urinary catheter. R3 was frequently incontinent of bowel. R3's pertinent diagnoses were encounter for orthopedic aftercare, central cord syndrome at C5, spinal stenosis cervical region (spaces in the backbone become too small causing pressure), spondylosis cervical region (wear and tear of the spine), weakness, and morbid obesity. Upon interview on 12/5/24 at 9:01 a.m. registered nurse (RN)-E stated R3 had made multiple complaints to the facility. She stated she recalled one complaint about call lights and R3 was given a highly sensitive button to push. She stated she could not recall the other complaints but would provide the documentation to the surveyor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon observation and interview on 12/5/24 at 12:20 p.m. R3 stated the concern she had was staff was not cleaning her peri-area appropriately or not at all and she has been in the hospital recently for a urinary tract infection. She stated she had made complaints to the facility and was told staff had been educated about the need to properly clean her. R3 stated she was educated in the hospital about the importance of making sure her peri-area is kept clean and dry. R3 stated earlier on 12/5/24 nursing assistant (NA)-B came into the room, got a washcloth wet and handed it to R3 to wash her face. R3 stated peri-care was not completed and her catheter bag had not been emptied. R3 pressed her call light and trained medication assistant (TMA)-B answered the light and emptied her catheter bag upon her request R3 had 1700 cubic centimeters (cc) of urine in the bag. TMA-B apologized for the bag not being emptied sooner. R3 told TMA-B that the surveyor would like to visualize her wounds, so a time was set-up for 1:30 p.m. on 12/5/24. Upon observation and interview on 12/5/24 at 1:45 p.m. RN-D, NA-B and an unidentified NA turned R3 onto her left side. R3's incontinent pad was dry and no odors present. R3 asked NA-C to please clean her up since she had only handed her a wash clothing for her face in the morning. NA-C stated she was going to go back complete peri-care for R3 but had not had time. The staff positioned R3 on her back. NA-C filed a basis with soap and water. NA-C cleansed between R3's labial folds and along the catheter tubing with the first wash cloth, there was dried blood and dried feces on the washcloth. NA-C used a second washcloth and wiped away again dried feces. The staff again placed R3 on her left side and NA-C used a third washcloth and wiped away a small amount of soft feces. A fourth washcloth was used and wiped away a small amount of soft feces in the buttock crease. NA-C then took a wet wipe and cleaned the rest of R3's buttocks. RN-D stated to NA-C R3 should have been cleaned-up in the morning to be kept clean and dry. Upon interview on 12/5/24 at 2:12 p.m. NA-C stated she was going back to clean-up R3 but had not had time. In addition, she stated R7 refuses cares often. She denied reporting to nursing staff or trying to get assistance from other staff. Upon interview on 12/6/24 at 2:54 p.m. the director of nursing stated R3 had been hospitalized multiple times with urinary tract infections. She stated R3 refuses cares often, but staff were able to properly clean her. A facility policy on activities of daily living for dependent residents was requested and not received.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to provide professional standards of practice for 2 or 3 residents (R6 and R9) reviewed when residents were observed wearing two incontinence briefs placed on them at the same time. Findings include: R6's quarterly Minimum Data Set (MDS) dated [DATE] indicated R6 had a BIMS score of 11 indicating cognitive impairment. R6 was dependent upon staff for oral and toileting hygiene, dressing and transferring. R6 was always incontinent of bowel and bladder. R6's pertinent diagnosis was Huntington's disease. R6's care plan dated 10/26/24 indicated for staff to check and change R6's incontinent brief every two hours. The care plan did not indicate R6 was to wear two incontinent briefs at the same time. Upon observation and interview on 12/6/24 at 11:05 a.m. hospice nursing assistant (NA)-D completed a bed bath on R6 and stated she had soaked through both briefs the facility had put on her. NA-D showed surveyor two saturated incontinent briefs in a plastic bag as he was exiting her room. He stated he finds often that residents on the unit are double briefed. Upon interview on 12/6/24 at 11:26 a.m. hospice registered nurse (RN)-J stated staff double brief R6 as she urinates often. She was uncertain how often facility staff checks and changes R6's incontinent brief or if they attempt to sit her on the toilet. Upon interview on 12/6/24 11:34 a.m. R6 stated yes staff puts two incontinent briefs on her. She stated no that hospice NA-D did not put two briefs on her. R9's quarterly MDS dated [DATE] indicated R9's BIMs score was three indicating severe cognitive impairment. R9 was dependent for toileting hygiene, bathing, and dressing. R9 was always incontinent of bowel and bladder. R9's pertinent diagnosis was Huntington's disease. R9's care plan dated 9/20/22 indicated R9's incontinent brief was to be checked and change every two hours. The care plan did not indicate R9 was to wear two incontinent briefs at the same time. Upon observation on 12/6/24 at 11:16 a.m. NA-D requested the surveyor to R9's room to show that R9 was seated in her wheelchair wearing two incontinent briefs. Upon interview on 12/6/24 at 11:36 a.m. NA- C stated it is not okay to double brief residents and she has never done so. Upon interview on 12/6/24 at 2:15 p.m. trained medication assistant (TMA)-A stated it was not okay to double brief a resident and he had seen it a few times on the unit, but he was not aware who of h staff was doing it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 12/6/24 at 2:54 p.m. the director of nursing (DON) stated it was not appropriate to double brief residents, staff should be checking and changing their incontinent brief at least every two hours. If a resident needed additional protection, they would expect staff to place a pad inside the incontinent brief if the care plan would instructions indicated. The DON was not aware that double briefing was taking place on the unit. A policy regarding quality of care was requested and not received.

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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** 44649 Based on observation, interview, and document review, the facility failed to appropriately assess and initiate interventions to minimize the risk for pressure ulcer development for 1 of 3 residents (R1) reviewed. Findings include: According to the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, revised 08-08-2024, indicated: -Pressure Ulcer/Injury (PU/PI) refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue. - Avoidable means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. -Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below). -Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan dated 10/19/24 indicated R1 had a potential for pressure ulcer development due to dementia, incontinence, refusal of cares and for assistance with mobility. R1's goal was to have intact skin, free or redness, blisters, or discoloration. R1's interventions were to notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration, etc. noted during baths or daily care and to explain and reinforce to resident the importance of adequate intake. The care plan identified on 10/21/24 R1 had inadequate protein-energy intake related to poor appetite as evidenced by consuming less than 50% of meals and weight loss greater than 5% in less than 30 days. R1's care plan failed to incorporate interventions to prevent the development of pressure ulcers. R1's dietary assessment dated [DATE] indicated R1 had significant weight loss of 5% in 30 days. R1 was at risk for malnutrition, weight loss, reduced muscle mass. R1 had inadequate protein intake and a Braden skin assessment score of 15 upon admission. R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 5 indicating he was severely cognitively impaired. R1 did not have behaviors or refusal of cares. R1 required extensive assistance with bed mobility, transfers, eating, and toilet use. R1's pertinent diagnosis was Parkinson's disease. R1 had no pressure ulcers. R1 was not receiving any skin and ulcer/treatments. R1's skin assessment dated [DATE] indicated R1 had dry skin, but no bruising, abrasions, skin tears, rash, or pressure injuries. R1's Braden Scale for Predicting Pressure risk (admission/readmission) dated 11/27/24 indicated R1 had a score of 16 and was at mild risk for pressure ulcer. A score of 15-18 indicated R1 was a mild risk. Mild risk interventions guideline included: -Frequent turning every two hours. -Maximal remobilization -Protect heels. -Manage moisture, nutrition, friction, and shearing. -If other major risk factors present (advanced age, poor dietary intake of protein, diastolic blood pressure below 60, hemodynamic instability) (the body cannot maintain consistent blood flow and pressure), advance to the next level of risk. R1's skin assessment dated [DATE], indicated R1 had a right hip moisture associated skin damage (MASD) stage 1 pressure ulcer (intact skin with a localized area of non-blanchable redness) 9x13 centimeters (cm), barrier cream and foam dressing applied. R1's family, primary care provider and the nurse manager were notified. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan revision date of 11/29/24 indicated the resident had potential for impairment to skin integrity related to thin and fragile skin of the right hip. R1's goal was to be free from skin injury through the review date of 1/18/25. R1's interventions were to monitor the location, size, and treatment of the skin injury. Report abnormalities, failure to heal, s/s of infection, maceration etc. to the health care provider. Identify potential causative factors and eliminate/resolve where possible. Avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short. The care plan did not identify that R1 had acquired an actual pressure ulcer nor the treatment for the pressure ulcer. The care plan did not include any additional interventions. R1's nursing progress note dated 11/29/24 at 1:05 p.m. indicated the R1's nurse practitioner (NP) was left a message updating her on R1's right hip ulcer requesting treatment. R1's nursing progress note dated 11/29/24 at 9:42 p.m. indicated NP would see R1 Monday (12/2/24) before referring R1 to the wound provider. No orders were provided. R1's electronic treatment administration record (eTAR) dated 11/29/24 indicated a nursing order was placed to cleanse area on right hip daily, pat dry and apply foam dressing to area. The order was placed on hold from 11/29/24 to 12/1/24. No other treatment orders for the wound were on the eTAR. R1's hospital admission note dated 11/29/24 at 10:30 p.m. indicated: -R1 had a pressure injury to his right toe. -R1 had a pressure injury or blanchable erythema middle sacrum, -R1 had a pressure injury Stage 2 to the right hip (a partial thickness loss of the skin, appearing as a shallow open sore or blister, where the top layer of skin and potentially the deeper layer are damaged resulting in a visible wound. -No other information was documented. R1's hospital Braden score dated 11/29/24 indicated R1 had a Braden score of 12 indicating R1 was at a moderate risk for developing pressure ulcers. R1's care progression note dated 12/2/24 indicated R1 was on comfort cares. R1 moaned and groaned with turns as right hip was tender from pressure injury, dressing was changed as needed. R1's palliative care encounter note dated 12/2/24 indicated family explained to the provider R1 was neglected at the facility which resulted in the pressure sores and poor nutrition. He began to decline at the facility eventually not eating independently, lying in bed most of the time and less responsive to staff and family. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 12/4/24 at 12:18 p.m. nursing assistant (NA)-A stated on 11/28/24 she found redness on R1's right hip and reported it to the nurse immediately. She stated it was a large triangle area over the bone with tinged blood. She stated it looked like he had laid on it a long time. She did notice redness on R1's coccyx, stating it did not have blood like his hip and that it did not need to be reported to the nurse because the NAs could use cream on the coccyx. NA-stated she did not notice any skin concerns with R1's feet. NA-A stated she was never told to reposition R1 when he was in bed or use any heel protectors. Upon interview on 12/4/24 at 12:40 p.m. registered nurse, (RN)-A stated he was the nurse who sent R1 to the hospital on 11/29/24. He was not aware of any skin concerns with R1. He stated there were not treatments ordered, no staff mentioned any skin concerns to him, and it was not R1's day for a skin assessment. Upon interview on 12/4/24 at 2:52 p.m. RN-B stated she was a float nurse and was the nurse who NA-A reported R1 had a pressure ulcer on his right hip. She stated his hip appeared to have a large upside-down triangle on it over his bony prominence. The skin was intact. R1 tended to lay on his right side often. RN-B stated she put barrier cream on the pressure ulcer and covered it with a dressing. She notified the family, the nurse manager, and the nurse practitioner. She did not follow-up to see R1 had received any skin care orders. Email correspondence on 12/5/24 at 7:42 a.m. from R1's family member (FM)-A revealed seven photos taken on 11/29/24 at approximately 7:00 p.m. in the hospital emergency room . Image 1 revealed a red, raised area on the anterior midsection of R1's right foot. Image 2 revealed bilateral redness and peeling of the skin on R1's buttock from the top of the intergluteal crease to below the sacrum into the gluteal folds. The redness covers one-half of the gluteus maximus bilaterally. Skin appeared dry. Inside the gluteal fold could not be observed. Image 3 and 4 revealed rightness over R1's entire right heel and redness on the bony prominence posterior to the right big toe. R1's foot appeared excessively dry. Image 5 and 7 revealed a blister, full eschar (scab) over the medial bony prominence of R1's right big toe. Image 6 revealed a raised, red area with three-quarters of the area open and appeared to have serosanguinous (blood and serum fluid from the wound) drainage, well defined edges. Peeling of the epidermis noted on the anterior and posterior part of the wound. Surrounding skin appeared dry. Upon interview on 12/5/24 at 12:12 p.m. the facilities Medical Director stated on the admission the facility completes a full skin assessment and then on a weekly basis the day resident's shower. He stated it depends if weekly skin assessments are enough stating it would be the nurse's judgement such as mobility, nutrition, diagnosis, etc. He stated skin breakdown can occur quickly for instance if a resident is septic (blood infection) or someone with vascular problems skin conditions can change within hours especially in the lower extremities (legs and feet). He stated in very debilitated residents the skin can change from one week to another. Regarding R1's coccyx pressure ulcer the NAs should have noticed that when they were changing R1's incontinent briefs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 12/5/24 at 1:12 p.m. RN-C the nurse manager stated she was aware of R1's wound. She stated the wound happened on a holiday 11/28/24 and was aware the NP would see R1 on the following Monday 12/2/24 however, R1 was transferred to the hospital on 11/29/24. RN-C stated she would have guessed R1 would have had a low Braden score and was surprised it was a 16. She stated he was admitted following significant weight loss, was incontinent of bowel and bladder, had dementia and was chair bound. She stated with a lower Braden score R1 would have had more interventions. RN-C did not elaborate on what more interventions could have been place. RN-C was shown pictures taken with permission of R1's family in the emergency room and stated the staff should not have missed those pressure ulcers. Upon interview on 12/6/24 at 4:30 p.m. R1's NP stated she recalled being called about redness on R1's hip measuring 9 x 13 cm. She stated she told the facility she would look at on 12/2/24 on her rounds. She stated she would have expected the facility to keep it covered, use barrier cream, assess, and turn and reposition him until then. She stated she was not informed of any other skin concerns for R1. She stated she read R1's hospital notes and the documented pressure ulcers and stated the facility should have caught those as those type of wounds would not have happened within hours during the transfer from the facility to the hospital. Upon interview on 12/6/24 at 2:54 p.m. the director of nursing (DON) stated the facility has skin assessments in place on admission and weekly thereafter. She stated the NAs are trained to notify the nurse with any skin changes and did notify the nurse with R1's hip pressure ulcer. She stated the facility staged the ulcer at a one and they should have been providing care there. She stated R1's other skin altercations should be noticed at the facility. A facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation Requirements with a revision date of 4/26/24 indicated all residents will be identified for their risk of developing pressure ulcers on admission/readmission by a registered nurse using the Braden Scale predicting pressure risk UDA. Those residents determined to be at risk will have the Braden scale completed weekly for the first four weeks. A systematic skin inspection will be made daily by the nursing assistant assigned to those residents at risk for skin breakdown. The nursing assistant is responsible for this and will report any abnormal findings or signs of skin impairment to the licensed nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44649 Based on observation, interview and document review the facility failed to ensure the proper temperature of food was served at breakfast on the 2nd floor WL unit. This had the potential to affect all 16 residents. Findings include: During observation on 12/6/24 at 8:41 a.m. staff was in the kitchenette area where scrambled eggs in steam tables. At 9:00 a.m. two nursing assistants and one trained medication assistant were dishing and serving breakfast. At 9:06 a.m. R6 was given pureed eggs to feed herself. She was heard shouting her eggs were cold, R6 was not offered to have her food heated up. At 9:10 a.m. surveyor tasted a spoonful of eggs that were sitting outside on a plate of the steam tables and the eggs were cold. Upon interview on 12/6/24 at 9:11 R9 nodded yes that her breakfast was cold. Upon observation and interview on 12/6/24 at 9:46 a.m. R7 stated his breakfast cold and always is. R7's food was sat on the table at 9:14 and he was fed at 9:21. R7's food was not covered on the table. Upon interview on 12/6/24 at 2:15 a.m. trained medication assistant (TMA) stated breakfast on the unit as difficult as the food is dropped off for the residents at various times, there are a lot of residents to feed and to get up by breakfast time. Upon interview on 12/6/24 at 2:52 p.m. the director of nursing stated she had not had any complaints about cold fold; however, food should be the appropriate temperate. A policy regarding food temperatures was not obtained.