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	12/24/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to ensure a baseline care plan was developed, within 48 hours that included goals and interventions to address resident's current needs, as required for 1 of 1 residents (R1) reviewed. Findings include: R1's entry Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included hemiplegia and hemiparesis, dysarthria (speech disorder/difficulty speaking); type 2 diabetes, dysphagia (difficulty swallowing) following cerebral infarction (ischemic stroke); aphasia (language difficulties because of a stroke), nontraumatic intracranial hemorrhage (bleeding in the brain that occurs without trauma or surgery), and tremor. R1's Nursing Admit Re-Admit Data Collection ([NAME]) was completed on 12/5/24, day of admission, and indicated R1 was admitted from the hospital following an ischemic cerebrovascular accident (stroke). Further, [NAME] indicated the following skilled services would be provided: medication and treatment administration, skilled nursing, therapy, and activities of daily living (ADL) assistance. ADL care planning was initiated however did not include individualized interventions on what ADL assistance R1 would require. R1's Functional abilities and Goals- Admission/Start of Skilled Care assessment dated [DATE], revealed eating which was the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident, R1 was determined to need supervision or touching assistance. R1's care plan dated 12/5/24, indicated R1 had an activities of daily living (ADL) self-care performance deficit, however R1's care plan lacked a goal and interventions directing staff on R1's ADL assistance required for bathing, bed mobility, dressing, eating, oral care, toileting, and transfers. Further, R1's nutrition care plan dated 12/6/24, indicated R1 was at risk for altered nutrition/hydration related to ischemic cerebrovascular accident (stroke), hemorrhage conversion, tremor, concern for myotonic dystrophy, type 2 diabetes and modified diet/textures with an intervention directing staff to monitor closely/report signs and symptoms of chewing/swallowing difficulties. R1's care plan lacked safety concerns and did not identify needs of supervision and assistance with ADLs, which included eating assistance. (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 12/24/2024
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/23/24 at 11:15 a.m., nursing assistant (NA)-C stated staff had access to each resident's care plan, which would direct staff one what each resident required for ADLs, including eating assistance. On 12/23/24 at 1:45 p.m., NA-B stated newly admitted residents each would have their own care plan that staff would be expected to review which would direct staff what each resident required for ADL assistance. On 12/23/24 at 2:17 p.m., NA-A stated for a newly admitted resident, each resident would have a care plan accessible to staff to direct them on what the resident required for assistance, which would include eating assistance. NA-A stated she could not recall if R1 was on a modified diet. Further, NA-A stated on 12/8/24, she assisted R1 in the morning with cares and served him breakfast and noon meal in his room. NA-A confirmed she did not supervise R1 while he was eating his meals and stated she had observed R1 in the dining room eating independently the day prior and was not aware R1 required supervision while eating. NA-A also confirmed R1's eating assistance and supervision was not on his care plan or on the NA's care guide worksheets. On 12/23/24 at 3:32 p.m., registered nurse (RN)-A stated she was responsible to complete each new admitting resident's care plan for the nursing department, and she was expected to complete the care plan within 48-72 hours, however, if there were several admissions, it could take longer. RN-A stated R1 was admitted to the facility on a Thursday 12/5/24, and discharged to the hospital on Sunday 12/8/24. RN-A stated R1 required staff assistance with all ADLs and RN-A confirmed R1's care plan was not completed within 48 hours. RN-A indicated staff were expected to communicate on each shift what R1 required. On 12/23/24 at 4:03 p.m., interim director of nursing (DON) stated the admitting floor nurse was responsible for completing the [NAME] assessment upon admission which would trigger the care plan. The admitting floor nurse would revise and add to each resident's care plan. Further, DON stated the care plan then would trigger the Kardex which was accessible to the nursing assistants and direct them on the new admissions care requirements. DON stated R1's assessments were completed on 12/5/24, and R1's care plan should have been updated within 48 hours, however DON confirmed it had not been updated. DON stated the facility had a procedure for new admission care plans and the unit manager was expected to review the resident's care plan the day after admission to ensure the care plan was completed as well as in the interdisciplinary team meeting twice a week. DON stated if R1 had not been admitted to the hospital on 12/8/24, his care plan would have been updated on Monday 12/9/24, by the nurse manager. When asked how staff were made aware of what assistance R1 required, DON stated that was a good question. DON indicated the information should have been on R1's care plan and DON was not aware what the staff referred to during the five days R1 was in the facility. Facility policy related to new admissions and baseline care plans was requested on 12/23/24 and 12/24/24, however, one was not provided.

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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** 43083 Based on interview and document review, the facility failed to provide adequate supervision during a meal for 1 of 1 residents (R1) reviewed, who required supervision due to swallowing disorder. Findings include: R1's entry Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included hemiplegia and hemiparesis, dysarthria (speech disorder/difficulty speaking); type 2 diabetes, dysphagia (difficulty swallowing) following cerebral infarction (ischemic stroke); aphasia (language difficulties because of a stroke), nontraumatic intracranial hemorrhage (bleeding in the brain that occurs without trauma or surgery), and tremor. R1's Order Summary dated 12/24/24, indicated R1 required a regular diet, soft and bite-sized texture, and moderately thick liquids as of 12/5/24. R1's Functional abilities and Goals- Admission/Start of Skilled Care assessment dated [DATE], revealed eating which was the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident, R1 was determined to need supervision or touching assistance. R1's Resident Dining assessment dated [DATE], indicated R1 had signs and symptoms of possible swallowing disorder exhibited by coughing or choking during meals or when swallowing medications. Consider referral for clarification as needed was not selected. Care planning for resident dining was initiated however, lacked person centered focus, goals, and interventions. Further, assessment indicated R1 was provided education regarding communication to staff any changes in pain when eating or swallowing difficulties (gagging when eating or drinking, unable to swallow saliva) and symptoms of silent aspiration (watery eyes, reddened face, runny nose). Barriers related to education or material provided included physical, cognitive and cues were required. R1's Speech Therapy Treatment Encounter Notes dated 12/6/24, indicated R1 required a regular diet, soft and bite sized textures, and moderately thick liquids. R1 lacked insight to impairments. R1's daughter endorsed increased challenges with swallowing, memory, and communication. R1's SLP (Speech Language Pathologist) Evaluation and Plan of Treatment dated 12/6/24, revealed clinical bedside assessment of swallowing R1 required supervision/assistance at mealtime due to swallow safety approximately 91-100% of the time. Further, assessment summary concluded patient demonstrated mild-moderate cognitive linguistic communication impairment and mild oropharyngeal dysphagia, required speech therapy services for interventions for swallowing and communication. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/24 at 10:53 a.m., family member (FM)-A stated R1 was admitted to the facility following two strokes and had failed a swallow study test, which R1 then required soft and bite sized food and moderately thick liquids. FM-A stated she had observed on a couple different occasions staff would leave R1 in his room, deliver a room tray and leave him to eat unattended, and speech therapy had identified he required assistance and observation while eating. Further, FM-A stated on 12/8/24, FM-A arrived at the facility at approximately 1:30 p.m. and observed R1 slumped over in the chair like he was asleep, however his eyes were open, he was unresponsive, and covered in food. FM-A stated a nursing assistant, and a licensed nurse were present in the room and stated they did not bring him to the dining room for meals that day. In addition, FM-A stated R1 was then admitted to the hospital and diagnosed with aspiration pneumonia. On 12/23/24 at 2:17 p.m., nursing assistant (NA)-A stated she could not recall if R1 was on a modified diet. Further, NA-A stated on 12/8/24, she assisted R1 in the morning with cares and served him breakfast and noon meal in his room. NA-A confirmed she did not supervise R1 while he was eating his meals and stated she had observed R1 in the dining room eating independently the day prior and was not aware R1 required supervision while eating. NA-A stated she was retrieving resident room trays following the noon meal and when she entered R1's room his food was all over him and the floor. NA-A went to retrieve a towel and placed it under R1's feet and continued to pick up other resident room trays. NA-A stated R1's family arrived, and they were not happy. In addition, NA-A stated neither R1's care plan nor the care guide worksheets identified R1 required supervision during meals. On 12/23/24 at 12:10 p.m., registered nurse (RN)-B stated she was not very familiar with R1 and had only worked with him one day however, recalled he had a diagnosis of dysphagia and had some stroke symptoms. RN-A could not recall if R1 was on a modified diet or required assistance or supervision while eating however, stated R1's care plan would identify diet, supervision, and assistance R1 would have required. On 12/23/24 at 1:31 p.m., RN-C stated she was the admitting nurse for R1 however that was the only day she had worked with R1. RN-C stated he was cognitively impaired and required thickened liquids. RN-C recalled R1 required supervision for meals and was observed in the dining room for meals and the nursing assistants would be present in the dining room to assist. Further, RN-C stated if a resident had dysphagia diagnosis or difficulty swallowing, the resident would require supervision during meals, which would be identified in the resident's care plan for staff to access and review. On 12/23/24 at 3:32 p.m. RN-A indicated R1 required staff assistance with all activities of daily living (ADL). RN-A stated the admitting floor nurse completed the functional assessment on 12/5/24, and identified R1 required supervision while eating and should have updated the care plan and communicated with the team. RN-A confirmed supervision was not identified in R1's care plan. Further, RN-A stated the day R1 was sent to the hospital for a change in condition on 12/8/24, the NA had delivered a room tray for the noon meal before the family arrived. RN-A indicated the family was upset when they arrived at the facility, entered R1's room, observed R1 slumped over in the chair, and food was all over him and the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/23/24 at 4:03 p.m., interim director of nursing (DON) stated if a resident required a dysphasic diet or thickened liquids, staff were expected to closely monitor or supervise the residents in the dining room. If the resident preferred to eat the meals in their room, staff were expected to be in the room as well assisting or supervising if they required assistance. DON stated if residents required assistance, it would have been identified in the resident's care plan. DON stated she was not familiar with R1 and was unsure if he required assistance with meals. DON reviewed R1's functional assessment and confirmed the assessment identified he required supervision while eating however, the care plan was not updated. DON stated R1 was admitted to the hospital and was unsure what the admitting diagnosis was. DON indicated the family chose for R1 not to return to the facility due to concerns of R1 not being cared for or checked on. Further, DON stated she investigated the family's concerns and interviewed NA-A. NA-A revealed she delivered R1's noon meal to his room and stayed with him while he ate. DON indicated a written statement had not been obtained from NA-A. DON was informed NA-A's interview with surveyor revealed different information. On 12/24/24, attempted interview with SLP-A was unsuccessful. Requested facility policy on 12/23/24 and 12/24/24, regarding supervision during meals and facility however, one was not provided.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to ensure the Facility Assessment identified the facility's staffing needs based on the care needs of the resident population. This deficient practice had the potential to affect all 92 residents who resided in the facility. Findings include: Review of Facility assessment dated [DATE], indicated the assessment was organized in six parts: demographics and census, facility resources, core requirements, competencies, plan, and measuring and monitoring. Further, the assessments indicated the facility assessment would serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources and may include the operating budget necessary to carry out the facility functions. However, the Facility Assessment lacked information on staffing levels needed for specific shifts, such as day, evening, and night and adjusted as necessary based on changes to resident population. On 12/23/24 at 3:32 p.m., registered nurse (RN)-A stated facility staffing was determined by resident care needs and facility staffing was managed and reviewed by the director of nursing (DON) and administrator. On 12/23/24 at 4:03 p.m., interim DON stated she was temporarily in the DON position due to a family leave however, stated the facility staffing was determined by the resident's acuity level. On 12/24/24 at 12:48 p.m., senior director (SD) stated he was assisting the facility while the administrator was on leave. SD stated facility staffing was determined based on resident census and their needs, however, SD was unsure on specific staffing numbers and indicated the information should have been in the facility assessment. Further, SD stated the facility assessment did not identify specific amount of how many staff were required and there were no other additional attachments regarding staffing information in the Facility Assessment.