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	01/29/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47790 Based on observation, interview and document review, the facility failed to provide medication as ordered by the physician for 1 of 3 residents (R4) reviewed for pharmacy services. Findings include: R4's Diagnosis List dated 1/14/25, indicated R4 had hepatic encephalopathy (a loss of brain function as a result of failure to remove toxins form the blood due to liver damage) and alcoholic cirrhosis of the liver (liver disease). R4's Physician's Orders dated 1/14/25, directed to give rifaximin (used to prevent liver failure) 550 milligrams (mg) two times a day starting 1/14/25. On 1/14/25 at 9:23 p.m., a progress note written by registered nurse (RN)-A indicated R4's rifaximin was on order from the pharmacy. On 1/15/25 at 10:15 a.m., a progress note written by licensed practical nurse (LPN)-A indicated R4's rifaximin needed price approved by the facility before it would be sent. On 1/16/25 at 10:47 a.m., an email written by the director of nursing (DON) to nurse practitioner (NP)-A indicated a need for the rifaximin to be reviewed by NP-A. On 1/16/25 at 11:41 a.m., an email written by NP-A indicated to hold the rifaximin for now, and NP-A would see R4 on 1/17/25. R4's electronic medication administration record (EMAR) dated 1/29/25, indicated R4 did not receive rifaximin from 1/14/25 through 1/16/25. On 1/29/25 at 10:45 a.m., RN-B stated on 1/16/25 during the day shift, R4 had an order for rifaximin, but the medication was not at the facility, so she could not give R4 the medication. Someone talked with NP-A on 1/16/25, and the medication was put on hold until R4 was seen by NP-A on 1/17/25. On 1/17/25, NP-A wrote orders for R4 to have lactulose (laxative that treats hepatic encephalopathy) in place of the rifaximin. If a resident does not have medications in house, the staff were expected to call the pharmacy and medical provider for further direction. (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
	245279	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 11:24 a.m., LPN-A stated on 1/15/25 the pharmacy had sent an approval for cost form for R4's rifaximin as it was expensive. She put the form under the nurse manager's door. She had not given R4 the ordered medication and had not called the medical provider. She had not called the medical provider because the medication was waiting to be approved by management due to cost. If the facility wanted her to call the medical provider on medications that were not administered, the facility should have made that clear to her. On 1/29/25 at 12:48 p.m., the consultant pharmacist (CP)-A stated R4 should have been taking medication for his hepatic encephalopathy per orders. Rifaximin was a critical medication for R4, and not getting the medication could put R4 a risk for symptoms of encephalopathy and could have caused hospitalization . The facility staff should be calling the medical provider if a resident was not getting ordered medications. On 1/29/25 at 1:48 p.m., the DON stated when a medication needed to be approved due to cost, the nurses were to give the request form to the nurse manager night away to be approved. That did not happen in this case. On 1/16/25, she was notified there was a high-cost medication for R4 that needed to be approved. She emailed NP-A on 1/16/25, to get an alternative medication for R4. The facility policy stated staff were to call the medical provider immediately if a resident was not going to get the medication ordered. She was not sure why the staff did not do this on 1/14/25 through 1/15/25. On 1/30/25 at 10:45 a.m., NP-A stated if R4 did not get a medication ordered, the facility should have reported it to her as a medication error right away. She was not updated until 1/16/25, two days after the first missed dose. R4 should have been taking something to help prevent his hepatic encephalopathy upon admission to the facility but was not, this could have caused an exacerbation to his symptoms. Medication error documentation was requested but not provided. The facility policy Local Pharmacy Medication Ordering dated 9/3/24, directed if a medication is not available to notify the physician immediately to determine whether the order should be changed or starting the medication can wait until it the medication comes from the pharmacy.