

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society Inver Grove Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50th Street East Inver Grove Heights, MN 55077	

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)
<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49337</p> <p>Based on interview and document review, the facility failed to ensure 1 of 3 (R1) residents reviewed for medication errors did not have properly transcribed orders for an antibiotic for an infected pressure ulcer. This medication error resulted in actual harm to R1 when she developed sepsis and was hospitalized. The facility implemented corrective action prior to the survey, so the deficiency was issued at past non-compliance.</p> <p>Findings include:</p> <p>Pressure Ulcer staging per the National Pressure Ulcer Advisory Panel (NPUAP):</p> <p>Stage 2 pressure ulcer: a partial-thickness skin loss with exposed dermis, the wound bed is viable, pink, and moist.</p> <p>Stage 4 pressure ulcer: a full-thickness skin and tissue loss with exposed muscle, ligament, cartilage or bone. Slough and/or eschar may be visible. Rolled edges or tunneling often occur.</p> <p>R1's 1/8/24 quarterly Minimum Data Set (MDS) identified she was cognitively intact, and required extensive assist of one to two staff for all activities of daily living. R1 had one Stage 2 pressure ulcer and one Stage 4 pressure ulcer.</p> <p>R1's care plan dated 4/8/24 included diagnoses of osteomyelitis, quadriplegia, history of stroke, and atherosclerosis of native arteries of right leg with ulceration of heel and midfoot.</p> <p>On 3/28/24 a report to the State Agency (SA) identified nurse practitioner (NP)-A ordered an antibiotic and new wound care orders for R1 on 3/13/24 for a right heel pressure ulcer infection. The order was not transcribed by the facility until 3/28/24, when the previous director of nursing (DON) found the written order in NP-A's office while organizing paperwork. The previous DON noted the order was not in R1's active orders. The facility was unable to determine how the written order ended up back in NP-A's office.</p> <p>(continued on next page)</p>

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
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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/4/24 a report to the SA identified licensed practical nurse (LPN)-A received a written order from NP-A on 3/13/24 for Bactrim (antibiotic) 200 milligram (mg) per 40 milliliter (ml), give 20 ml BID (twice a day) via feeding tube for 10 days. The written order also included updated wound care orders. The report indicated LPN-A had an issue entering the medication into the electronic health record (EHR) system and asked a coworker for help. The medication was not entered into the EHR on 3/13/24. The antibiotic was delivered by the pharmacy and placed in the medication fridge but none of the nursing staff noticed it in the fridge or verified if the medication was documented in the EHR for administration.</p> <p>R1's Active Orders dated 3/13/24 written by NP-A directed for R1's right heel wound to discontinue old wound orders and to clean with wound cleanser, apply moist blue foam dressing and cover with border sacral foam dressing. Change dressing daily and as needed when soiled. The antibiotic order directed Bactrim 200 mg per 40 ml, give 20 ml via feeding tube twice daily for ten days.</p> <p>R1's Active Orders dated 3/28/24 verified the antibiotic order was not started until 3/28/24. The orders directed to clean with wound cleanser, apply moist gauze to wound bed, cover with dressing pad and wrap with Kerlix. Change twice a day.</p> <p>R1's Wound Care Data Collection assessments for R1's right heel indicated the following:</p> <p>3/7/24: The assessment indicated there was drainage leaking around the dressing and the condition of tissue surrounding the dressing was death tissue. It indicated eschar (dead tissue that sheds off after an injury) as 99% and noted there was a strong odor.</p> <p>3/12/24: The assessment identified R1's right heel as a deep tissue injury, unstageable and covered with eschar.</p> <p>3/19/24: The assessment identified the dressing was present and intact, with drainage present on the dressing. Another assessment was completed on 3/19/24 which indicated R1's heel was noted as having a foul odor and discharge.</p> <p>3/21/24: The assessment identified the condition of the tissue surrounding the dressing was slightly macerated (the softening and breaking down of skin resulting from prolonged exposure to moisture).</p> <p>3/23/24: The assessment identified the heel was pink, intact and macerated.</p> <p>3/24/24: The assessment identified the dressing was present, intact, with drainage present on the dressing. There was no leaking around the dressing and the skin around the dressing was macerated. The assessment indicated there was not a presence of possible complications, increasing area of ulceration or soft tissue infection. The wound margins were checked off as reddened.</p> <p>3/25/24: The assessment identified the condition of the tissue surrounding the dressing was macerated, white, dry and flaky, moving further from the wound bed.</p> <p>3/26/24: The assessment identified the surrounding skin of the heel was macerated, denuded and reddened.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/9/24 at 2:50 p.m., NP-A stated she was unaware R1's antibiotic and wound care orders had not been transcribed. She would have expected the nurses to let her know. She was updated about the worsening of the heel wound on 3/28/24, and noticed it herself when she saw it that day. From her assessment on 3/28/24, she was concerned about R1 being septic due to the worsening heel pressure ulcer, and decided to have R1 sent to the hospital.</p> <p>The facility policy Physician/Practitioner Orders - Rehab/Skilled revised 4/1/24 directed orders should be processed and transcribed into Point Click Care (PCC) immediately upon receipt of an order. Once the order is entered into PCC, the order will populate the appropriate electronic administration documentation location within the application.</p> <p>The past non-compliance began on 3/13/24 and the deficient practice was found and corrected on 3/28/24. The facility provided education to all nurses for implementing new provider orders. On 3/28/24, a skilled nursing facility shift form report was implemented to aid in hand off reports about new provider orders. Expectations for the wound nurse position was clarified and education was provided to nursing staff. A standing order workflow sheet was created and provided to staff. An audit of all active antibiotic orders and new provider orders from the previous 30 days was started on 3/28/24.</p>		