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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Comforcare	1201 17th Street NE Austin, MN 55912

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 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** 51576 Based on observation, interview, and record review the facility failed to comprehensively assess, monitor, and implement interventions for 1 of 1 (R1) resident following a fall. Findings include: R1's face sheet dated 3/5/25, identified an admitted [DATE] and diagnoses of obesity (a condition of having too much body fat), diabetes mellitus (a condition that affects how the body uses sugar as fuel), and heart failure (condition in which heart doesn't pump blood as well as it should). R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact and dependent for transfers. R1's activities of daily living (ADL) focus care plan dated 1/21/25, identified R1 was assist of two using total mechanical lift for bed mobility and assist of two with sit to stand mechanical lift for toilet use. ADL care plan revised on 1/27/25 to transfer between surfaces: stand pivot transfers with front wheeled walker from edge of bed to wheelchair with contact guard assist of one staff. The care did not identify specifically when to use the sit-to-stand vs full body mechanical lift for safe transfers. Review of R1's incident report on 2/4/25 at 10:30 p.m., identified nursing description: nursing assistant went into resident room and found resident on the floor on the side of the bed. Assisted of two with total mechanical lift into wheelchair. Stated resident refused vital signs, skin assessment, range of motion and neurologic exam. Incident report identified R1's provider was not notified of fall until 11:53 p.m. Review of R1's progress notes on 2/4/25, did not identify that a fall had occurred on 2/4/25 at 10:30 p.m., nor any education provided to resident about the risks of not allowing vitals, range of motion (ROM), or neurological exam or provider notification of the refusal. Additionally did not identify a mobility assessment for safe transfers after a fall. During an interview on 3/6/25 at 10:29 a.m., R1 stated since her fall on 2/4/25 where she fractured her clavicle, she has had pain and feel like this has made her go backwards. R1 stated she was supposed to return to the assisted living the week she fell and now she is not able to return until she is able to do things for herself and is using the total mechanical lift now. (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: 245317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER: Good Samaritan Society - Comforcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 1201 17th Street NE Austin, MN 55912	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/25 at 1:40 p.m., licensed practical nurse (LPN)-A stated she completed the incident report for a fall that occurred on 2/4/25 at 10:30 p.m., that was reported to her. LPN-A did not observe R1 on the floor nor perform a comprehensive assessment after the fall. During an interview on 2/28/25 at 4:23 p.m., nursing assistant (NA)-B stated prior to the fall on 2/4/25 at 10:30 p.m., R1 was sleeping in her wheelchair and he assisted her bed and she appeared weak and was having difficulty with the transfers. NA-B had R1 sit on the edge of the bed and left the room to retrieve the sit to stand mechanical lift to transfer her to the bathroom and when he returned R1 was seated on the floor near her bed. He stated he informed licensed practical nurse (LPN)-C of the fall, and she entered the room, but unsure if she assessed R1 prior to getting her off the floor. During a follow up interview on 3/5/25 at 11:19 a.m., NA-B stated he did not inform the nurse that R1 was weak prior to attempting a transfer before the first fall at 10:30 p.m., he also stated, I should have told the nurse she was weak before she fell at 10:30 p.m., but did not do this. During an interview on 3/4/25 at 2:37 p.m., LPN-C stated she was informed by NA-B that R1's fall on 2/4/25 at 10:30 p.m. and when she entered R1's room she was on the floor. LPN-C stated she did not perform any assessments because R1 would not allow assessments following the fall and did not document the refusals of assessments. LPN-C instructed staff to use the mechanical lift to get her in her wheelchair and she was not present in the room when staff transferred her off the floor. LPN-C stated, I am not sure why I would have not done an assessment. She stated normal practice in the facility if the nurse is informed of a fall to do vital signs, ROM, and neurological exam before the nursing assistants can transfer a person off the floor. During an interview on 3/4/25, registered nurse (RN)-B stated if a nurse finds a resident had fallen, they will assess the resident, perform range of motion, and if unwitnessed do neurological exam. If a resident refuses this assessment, the nurse should provide education to that resident, and notify the provider. During an interview on 3/4/25, at 11:23 a.m. interim director nursing (IDON) stated the nurse should have assessed R1 her before getting her off the floor. During an interview on 3/5/25 at 11:40 a.m., medical doctor (MD) stated her expectation would be that nursing should perform an assessment on any resident following a fall, paying close attention to range of motion and vitals. If a resident refused a comprehensive assessment, she would expect the provider to be notified of such refusal. Review of the facility's Fall Prevention and Management policy dated 7/29/24, identified procedure for a fallen resident: -Do not move resident. -A nurse must observe the resident and perform a full-body exam to determine if there may be suspected injury and direct whether to move the resident. -Obtain blood pressure, pulse, respiratory rate, pulse oximetry and temperature. Check blood sugar if resident is symptomatic of blood glucose issues. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If the fall was not witnessed, neurological checks are required and must be documented in the medical record. -Continue to monitor the resident's condition; communicate updates as needed. -Review resident's medications for recent changes or medication that could contribute to a fall. -If teaching is done, it must be documented in the medical record. -Review and update care plan with any changes/new interventions.

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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** 51576 Based on observation, interview and document review the facility failed to comprehensively assess each fall, identify causal factors to determine the reason for fall, identify appropriate individualized interventions to prevent or decrease the risk of future falls for 2 of 3 residents (R1 and R5) reviewed for falls. Findings include: R1's face sheet dated 3/5/25, identified an admitted [DATE] and diagnoses of obesity (a condition of having too much body fat), diabetes mellitus (a condition that affects how the body uses sugar as fuel), and heart failure (condition in which heart doesn't pump blood as well as it should). R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact and dependent for transfers and toileting. Always continent of bladder and frequently incontinent of bowel. R1's MDS indicated she had falls in the last two to six months prior to admission. R1's activities of daily living (ADL) focus care plan dated 1/21/25, identified R1 was assist of two using total mechanical lift for bed mobility and assist of two with sit to stand mechanical lift for toilet use. R1's care plan dated 1/21/25 did not address a bowel/bladder focus that would identify R1's individualized toileting plan/schedule. ADL care plan revised on 1/27/25 to transfer between surfaces: stand pivot transfers with front wheeled walker from edge of bed to wheelchair with contact guard assist of one staff. R1's fall focus care plan initiated on 1/21/25, identified at risk for fall related to (left blank). Goal to be free from falls. Interventions included ensure that resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. R1's admission fall risk assessment dated [DATE], identified low risk for fall. R1's fall risk assessments dated 1/27/25, 2/1/25, and 2/9/25, identified low risk for falls. R1's fall risk assessment dated [DATE], completed due to fall, identified medium risk for falls. R1's fall risk assessment dated [DATE], identified high risk for falls. Review of facility's incident report log on 2/27/25, identified R1 had seven falls between 1/23/25 and 2/26/25. R1 had an additional fall on 3/4/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's incident report on 1/23/25 at 11:55 p.m., identified R1 was found seated on the floor and slipped from bed. R1 had pain in her inner part of her right leg, but no signs of evidence of concerns. No open skin areas or redness. Immediate action taken: was assisted to bed with total mechanical lift, vital signs and neurological exams began. New intervention to remind R1 to use call light for assistance with sitting on edge of bed. Facility investigation form undated, identified cause of incident was that R1 self-transferred from laying to sitting on edge of bed without assistance. Slippery nightgown was felt to be cause of R1 slipping from edge of bed, however, there was no indication interventions were developed and implemented to decrease falls related to R1's slippery night gown. R1's care plan was updated on 1/24/25 educate R1 to use call light for assistance with sitting on the edge of bed. R1's incident report on 1/27/25 at 2:30 a.m., identified R1 was found on the floor. Door was closed, and call light not turned on. Call light was within reach. R1 was attempting to get up and go to the bathroom by herself. The incident report did not identify if R1 was incontinent or continent. Immediate action taken was assisted off the floor to the bed. Once in bed, R1 was transferred to the bathroom. New intervention added to keep door partially open. Facility investigation form undated, identified causal factor as R1 self-transferred to edge of bed without calling staff for assistance. There was no indication the investigation included an assessment to determine if R1's toileting needs were met prior to the fall and/or if R1's toileting care plan was appropriate. R1's care plan was revised on 1/27/25 with the addition of keep door partially open. R1's incident report dated 2/1/25 at 3:00 a.m., identified R1 was found sitting on the floor, resting her back near her bed. R1's bed in lowest position and call light within reach. R1 was assisted to go to the bathroom around midnight. R1 stated she was trying to go to the bathroom. Immediate interventions taken was assisted back to bed with mechanical lift. New intervention: colorful signs put in room to friendly remind/encourage resident to use call light and wait for assistance with all transfers. Facility investigation form dated 2/4/25, identified cause of fall as self-transfer attempt by resident. This is the third fall from the edge of bed due to self-transfers. Facility form did not identify R1's needs to use the bathroom prior to the fall. Facility form was unsigned by director of nursing, administrator, social worker, and medical director. R1's incident report dated 2/4/25 at 10:30 p.m., identified R1 was found on the floor on the side of the bed. Immediate action taken was assist of two with total mechanical lift into wheelchair. R1 refused vital signs, skin assessment, range of motion, and neurological exam. Facility investigation form undated, identified cause of fall that R1 often sits self-up on the edge of the bed and then slips from bed to the floor. Although the report identified she slips off the edge of the bed, there was nothing implemented to prevent this from reoccurring. R1's incident report dated 2/4/25 at 10:41 p.m., identified R1 was in her wheelchair and two nursing assistants assisted R1 to the bathroom by sit to stand mechanical lift. R1 was not standing, and left arm went up and slid out of sling, while she kept hanging on with right arm, being two inches off the ground and landed her bottom on the bathroom floor. R1 had pain in right shoulder. Immediate action taken was ambulance called for transport to hospital. Facility investigation form undated, identified cause of incident that R1 let go of sit to stand mechanical lift with left hand leaving all her weight on the right arm. R1 heard a pop and was lowered to the ground. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's progress note dated 2/5/25 at 12:06 a.m., identified R1 left facility via ambulance at 11:20 p.m. R1's progress note dated 2/5/25 at 2:10 a.m., identified R1 returned from emergency department (ED) with diagnosis of fracture of clavicle closed initial right. Review of hospital medical records dated 2/5/25, identified R1 was seen in ED due to pain in right shoulder after a fall and imaging showed an acute mildly displaced fracture of the right mid clavicle. R1 to wear sling on right arm and non-weight bearing for six weeks. R1's incident report dated 2/26/25 at 1:54 a.m., identified R1 was found sitting on the floor by the doorway in her room. R1 stated she slid out of bed after attempting to adjust herself in bed. Immediate action taken was vital signs, range of motion, neurological exam, and skin observation. Assisted back to bed with total mechanical lift. Intervention: colorful signs put in room to friendly remind/encourage resident to please use call light when needs assistance-we are here to help you. Although the analysis identified root cause of sliding out of bed there was no indication R1's care plan was revised to address the causal factors. R1's care plan previously amended on 2/1/25 for colorful signs put in room to friendly/encourage resident to please use call light and wait for staff assistance/help with all transfers. R1's incident report dated 3/4/25 at 2:32 a.m., identified R1 was found on the floor with back scratcher in hands. Resident stated, I slid out of bed, same as always, went on the floor on my buttocks. Immediate action taken was vital signs, neurological check, skin observation, range of motion. Assisted back to bed via total mechanical lift. Facility investigation form dated 3/4/25, identified cause of fall stated she fell asleep while sitting on the edge of bed. New intervention added to care plan of one-hour checks while in bed. Although the incident report identified causal factor of sliding out of bed per R1 there was no indication R1's care plan was revised to include an intervention for sliding out of bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/25 at 4:23 p.m., nursing assistant (NA)-B stated prior to the fall on 2/4/25, shortly before 10:30 p.m., NA-B went into R1's room to find her sleeping in her wheelchair. NA-B pushed R1 next to her bed to complete a stand pivot transfer. However, during the transfer to the edge of the bed R1 seemed really weak and had difficulty standing. R1 stated she had to go to the bathroom so NA-B left the room to get the sit-to-stand mechanical lift because R1 was having too much difficulty with standing. NA-B explained staff could use mechanical lifts when residents suddenly became unable to complete transfers. This was also care planned for R1. When NA-B returned to the room R1 was seated on the floor next to her bed. NA-B stated trained medication aide (TMA)-A and himself assisted R1 from the floor using a full body mechanical lift and placed R1 in her wheelchair. LPN-C was not in the room during the transfer. NA-B indicated once R1 was in her wheelchair she requested to use the bathroom. TMA-A and NA-B used a sit-to-stand mechanical lift to transfer R1 from the wheelchair to the toilet. They raised R1 up in the lift, pushed her towards the bathroom, and as they were turning toward the toilet, R1 became weak in the legs and began hanging in the lift after letting go with her left hand and was hanging on to the lift bar with her right hand. R1 then reported she had pain then she heard a pop at which point she let go with her right arm. NA-B stated we then lowered R1 to the ground. NA-B informed LPN-C of the R1's fall and she came into R1's bathroom. R1 was then sent to the hospital. During a follow up interview on 3/5/25 at 11:19 a.m., NA-B stated he did not inform the LPN-C that R1 was weak and unable to stand prior to the fall from side of the bed at 10:30 p.m. NA-B stated, I should have told the nurse she was weak before she fell at 10:30 p.m., but did not do this. During an interview on 3/4/25 at 2:37 p.m., LPN-C stated she was informed by NA-B of R1's fall on 2/4/25 at 10:30 p.m., When LPN-C entered R1's room R1 was seated on the floor next to her bed. LPN-C instructed staff to use the total mechanical lift to transfer her from the floor to her wheelchair. During an interview on 3/4/25 at 11:45 a.m., interim director of nursing (IDON) stated R1's falls were not investigated thoroughly to determine if R1's basic needs were met such as toileting and indicated the cause of R1's falls on 1/27/25, 2/1/25 and 2/4/25 was that she was attempting to go to the bathroom each time and that a toileting plan should have been added at that time due to R1 being dependent on staff with toileting. During an interview on 3/6/25 at 10:29 a.m., R1 stated since her fall on 2/4/25, where she fractured her right clavicle, and has gone backwards. R1 stated she was supposed to return to the assisted living now she was not able to return until she was able to do things for herself and was using the total mechanical lift now for all transfers. R5's face sheet dated 3/5/25, identified diagnoses of fracture of left lower leg (broken bone in leg), Alzheimer's disease (progressive disease the destroys memory), history of falling, and bipolar disorder (disorder with episodes of mood swings). R5's admission MDS dated [DATE], identified R5 had severe cognitive impairment and dependent for transfers and had 1 fall since admission without injury. R5's ADL focus care plan dated 1/28/25, identified self-care deficit related to Alzheimer's disease and recent falls at home. Goal to improve current level of functioning. Interventions dated 1/28/25 identified for toilet use assist of two with total mechanical lift. Revised on 2/28/25 to use assist of one and gait belt. Transfer assist of one and gait belt stand pivot (please use total mechanical lift as needed to transfer into bed or wheelchair) not putting weight on left lower extremity. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's fall focus care plan dated 1/28/25, identified R5 is at risk for falls due to history of falls, weakness, and unsteady gait/balance. Goal will be free from falls. No interventions identified. R5's focus care plan dated 1/29/25, identified R5 had impaired cognition. Goal will be able to communicate basic needs on daily basis. Interventions were to check on frequently due to self-transfer attempts for safety and to help potentially reduce falls. Fall Risk Assessments completed on 2/8/25, 2/11/25, and 2/15/25, identified R5 was at high-risk for falls. Falls tool action plan not marked as initiated. No fall risk assessment was provided on admission. Review of Facility's incident report log on 2/27/25, identified R5 had five falls between 1/29/25 to 2/22/25. R1 had two additional falls on 3/1/25 and 3/4/25. The falls are identified as follows: R5's incident report dated 1/29/25, identified a fall at 4:20 a.m., R5 was found seated on the floor with her back resting on the side of the bed. Bed was in lowest position and call light within reach. Immediate action taken was a fall mat placed on side of bed. Care plan intervention initiated on 1/29/25 with fall mat placed next to bed and frequent check due to self-transfer attempts for safety to help potentially reduce falls. R5's incident report dated 2/11/25, identified a fall at 7:45 p.m., R5 was in doorway of room. Immediate action taken was to remind resident on importance of using the call light when needing assistance and to not self-transfer. R5's fall record did not include a comprehensive analysis of fall nor identify possible root cause. R5's care plan revised on 2/11/25 to remind frequently to not self-transfer. R5's incident report dated 2/15/25/25, identified a fall at 4:02 p.m., R5 was found on the floor in her room seated on her knees. Immediate action taken was assisted off the floor, vital signs, taken to the bathroom, and then placed in wheelchair. Facility fall investigation form dated 2/15/25, identified cause of incident was resident yelling for help, she was leaving her room to find help, and the care plan was amended to remind resident to put on the call light and a sign was put on her table. R5's incident report dated 2/18/25 at 8:50 p.m., identified a fall when R5 was found scooting out of her room on her bottom. Immediate action taken was a skin assessment, vital signs, and range of motion. R5 was assisted by two staff using the total mechanical lift to bed. Facility investigation form dated 2/19/25, did not include a comprehensive fall analysis however identified causal factor of fall as resident was scooting on buttocks out of her room and she stated she was going to the movies. The care plan amended: if awake in room, encourage to come to commons area for better supervision. R5's care plan intervention revision on 2/19/25 if awake in bed, encourage to get up in wheelchair and come out of room into commons area for better supervision. R5's incident report dated 2/22/25 at 12:00 a.m., identified R5 was found scooting on buttocks on the floor near her doorway. R5's fall record did not include a comprehensive analysis of the fall nor identify root cause and it was not evident R5's care plan was revised. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's incident report dated 3/1/25 at 9:45 p.m., identified R5 was found on floor scooting self on floor in the direction of the bathroom. Immediate action taken was vital signs, neurological exam, range of motion, and skin observation. R1 was incontinent of urine. Assisted by two staff with total mechanical lift to bed. Intervention added colorful signs placed in room reminding resident to use call light for help. R5's care plan revised on 3/2/25, to place colorful signs placed in room to remind resident to call for help. R5's fall record did not include a comprehensive analysis of the fall that included and addressed R5's toileting needs. R5's incident report dated 3/3/25 at 9:15 pm., identified R5 was found lying on the floor. Immediate action taken was vital signs, neurological exam, body exam, range of motion. Assisted with two staff back to bed with total mechanical lift. Intervention of soft touch call light put in place. R5's care plan updated on 3/4/25 to soft touch call light put in place. R5's fall record did not include a comprehensive fall analysis nor identify potential root cause. During an interview on 3/6/25 at 1:03 p.m., IDON stated R5's care plan interventions to remind to use the call light/signs would not be appropriate with her cognition. IDON further stated the falls for R1 and R5, a thorough investigation was not performed to determine if basic needs were met and to determine a root cause. We tried to put interventions in place, but they are not always related to the root cause and should have been. DON also stated when the interdisciplinary team meets each week to discuss falls, we should be adding a summary in the resident's chart, but this has not happened lately. The care plan should be updated timely with any changes of new interventions/changes so staff are aware. Review of the facility's Fall Prevention and Management policy dated 7/29/24, identified procedure for a fallen resident: -Do not move resident. -A nurse must observe the resident and perform a full-body exam to determine if there may be suspected injury and direct whether to move the resident. -Obtain blood pressure, pulse, respiratory rate, pulse oximetry and temperature. Check blood sugar if resident is symptomatic of blood glucose issues. -If the fall was not witnessed, neurological checks are required and must be documented in the medical record. -Continue to monitor the resident's condition; communicate updates as needed. -Review resident's medications for recent changes or medication that could contribute to a fall. -If teaching is done, it must be documented in the medical record. -Review and update care plan with any changes/new interventions. Review of facility's Care Plan Policy dated 12/2/24, identified the care plan will be modified to reflect the care currently required/provided for the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 51576 Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP-where gown and gloves used for high contact resident care activities) was used for 1 of 3 residents(R3) observed for EBP. In addition, the facility failed to ensure handwashing/hand hygiene was implemented for 2 of 7 residents (R6, R7) observed for handwashing/hand hygiene. Findings include R3's face sheet dated 3/6/25, identified heart failure (condition in which heart does not pump blood as well as it should), and calculus of bile duct (bile duct stones). R3's care plan focus dated 4/16/24, identified enhanced barrier precautions indicated due to indwelling medical device (biliary drainage tube). Interventions to use gown and gloves when performing high contact activities (dressing, transferring, providing hygiene, repositioning, device care or wound care). During an observation on 2/27/25, at 11:15 am, R3 was in her room where nursing assistants (NA)-A and NA-C placed socks and pants on R3 with dressing, then applied a lift sling under her while turning her side to side. NA-A and NA-C then performed a transfer. NA-A and NA-C did not wear gown or gloves during cares or during the transfer. During an interview on 2/28/25 at 9:21 a.m., NA-A stated gown and gloves should be worn when performing any close contact care for any resident that is on EBP. R7's face sheet dated 3/5/25, identified diabetes mellitus (condition that affects how the body uses sugar as fuel), heart failure, and absence of left leg below knee. During an observation on 3/4/25 at 9:12 a.m., R7 was in bathroom seated on the toilet, NA-D applied gloves, however, did not perform hand hygiene before applying. NA-D then instructed R7 to stand and cleansed her perineal area (region located between the anus and genitals), NA-D then adjusted R7's clothing and adjusted R7's oxygen tubing on her face. NA-D did not remove gloves or perform hand hygiene after perineal cares. R6's face sheet dated 3/6/25, identified diabetes mellitus and kidney disease (condition where kidneys have been damaged). During an observation and interview on 3/4/25 at 9:30 a.m., R6 was seated on the toilet in the bathroom, NA-D entered R6's room and applied gloves. NA-D did not perform hand hygiene prior to applying gloves. NA-D washed R6's back and cleansed her perineal area. NA-D removed gloves and applied a new pair of gloves. Hand hygiene/handwashing was not performed prior to applying new gloves. NA-D assisted R6 with a transfer to her wheelchair, then opened up R6's drawer and removed a shirt and placed it on R6's upper body. NA-D then took R6's drinking cup and left room to fill in the facility kitchenette, however, did not remove gloves or perform hand hygiene. NA-D stated hand hygiene should be done before and after entering a resident's room, before and after cares, before touching drinkware, and before and after removal of gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Comforcare	1201 17th Street NE Austin, MN 55912

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/25 at 12:33 p.m., director of nursing (DON) stated her expectation for staff to use EBP (gown and gloves) for any personal cares for a resident identified on these precautions and to perform handwashing/hand hygiene before and after leaving a room, before and after cares, after removal of gloves. Review of the facility's Standard and Transmission Based Precautions dated 4/2/24, identified that enhanced barrier precautions (gown and gloves) needed during high-contact resident care activities for residents with chronic wounds, indwelling medical devices (central lines, urinary catheter, feeding tubes and tracheostomies). Review of the facility's Hand Hygiene policy dated 3/29/22, identified all employees in patient care areas will adhere to the 4 Moments of Hand Hygiene. 1. Entering room. 2. Before clean task 3. After bodily fluid/glove removal 4. Exiting room