

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245318	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - International Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 Keenan Drive International Falls, MN 56649	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on observation, interview and document review, the facility failed to ensure an electric wheelchair was maintained in working order for 1 of 1 resident (R23) reviewed for accommodation of needs.</p> <p>Findings include:</p> <p>R23's annual Minimum Data Set (MDS) dated [DATE], identified R23 had intact cognition and used a motorized wheelchair. R23 was independent with mobility once seated in his motorized wheelchair. Diagnoses included paraplegia, dependence on wheelchair and autonomic dysreflexia (a dangerous syndrome involving an overreaction of your autonomic nervous system).</p> <p>R23's care plan dated 3/15/24, identified R23 had limited physical mobility related to paraplegia from spinal cord injuries and weakness evidenced by R23's need for specialty wheelchair. The goal was for R23 to remain independent with locomotion in the facility. Interventions included use of motorized wheelchair in the facility.</p> <p>On 11/19/24, R23 was lying in bed watching television. A manual high back wheelchair was stored in the shower area of R23's room and a motorized wheelchair was positioned against the wall in the room. R23 stated lightning hit the nursing home building a few months ago and fried his motorized wheelchair. R23 did not know why the facility had not attempted to repair the chair for him. R23 was told he needed a new battery and that is all he had heard about it. The nurse reported the problem to maintenance and maintenance told R23 they were going to look into getting him a battery for the wheelchair and that was two to three months ago. The manual wheelchair the facility provided R23 to use was uncomfortable for him and he was unable to sit up straight when he was seated in it or recline the wheelchair back. R23 had autonomic dysreflexia and when he had a spell he would pass out and needed to be reclined back immediately. R23 was able to sit fully upright and to recline when needed in his motorized wheelchair. R23 owned the motorized wheelchair but felt it was the facility responsibility to repair because he knew it quit working when the building had been hit by lightning. His chair had been plugged in at the time and made a loud beeping noise and then did not work again after that.</p> <p>R23's medical record was reviewed and lacked evidence the facility had made any effort to assess, evaluate or discuss the broken motorized wheelchair with R23.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 11/20/24, at 10:49 a.m. nursing assistant (NA)-A stated R23 did not use his motorized wheelchair. The facility had been hit by lightning about two and 1/2 months ago and R23's motorized wheelchair would not take a charge after that. R23 used the manual wheelchair when he would get out of bed, for special things like haircut or celebrations.</p> <p>When interviewed on 11/20/24, at 10:53 a.m. trained medication aide (TMA)-A stated R23's motorized wheelchair did not work, and it needed a new battery. TMA-A did not know who was helping R23 fix his wheelchair, he just knew it has not worked for at least a month.</p> <p>When interviewed on 11/20/24, at 11:00 a.m. registered nurse (RN)-C stated she was aware R23's motorized wheelchair was not working as the battery would not charge. RN-C stated she reported the issue to maintenance. RN-C was upset when she came back from her vacation and found R23's motorized wheelchair had not been fixed. R23's motorized wheelchair absolutely should be repaired.</p> <p>A joint interview was conducted on 11/20/24 with the director of nursing (DON) and maintenance staff (M)-A. The DON stated she was not aware R23's motorized wheelchair was not working and R23 had a right to have his motorized wheelchair in working order. M-A stated he was made aware of R23's wheelchair not working, and M-A told R23 to use the chair more and run down the battery before recharging it, as it was developing a memory. M-A was not aware the motorized wheelchair did not take a charge at all. R23 had mentioned something about a lightning strike but that had just messed up the facility's television programming and had not interfered with the facility's electrical equipment. The occupational therapist had stated any maintenance or repairs would have to go through R23 and/or his family but he was not sure if anyone had discussed the issue with R23.</p> <p>On 11/21/24, at 10:00 a.m. M-A stated he tried a different charger with no success and now was looking into obtaining a different battery to try. M-A stated R23 had told him the chair had been plugged in during the lightning strike and had made a loud beeping sound, the damage could have been caused by the lightning strike, it was hard to tell.</p> <p>The facility's Accommodation of Resident Need policy dated 9/16/24, identified the resident had a right to reside and receive services with reasonable accommodation of resident needs and preferences. The facility should adapt or individualize things such as desires and unique needs such as furniture that enhances the resident's ability to maintain their independence.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40948</p> <p>Based on interview and document review, the facility failed to ensure medications were coded correctly on the Minimum Data Set (MDS) for 1 of 5 residents (R27) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R27's quarterly MDS dated [DATE], identified R27 had severe cognitive impairment. Diagnoses included Alzheimer's, non-Alzheimer's dementia, diabetes, and depression. The MDS identified R27 received an antianxiety medication.</p> <p>R27 medication administration report (MAR) for the month of October 2024, identified R27 received Trazodone (an antidepressant) for generalized anxiety disorder, restlessness, and agitation. The MAR/orders did not identify R27 was receiving an antianxiety medication during the MDS lookback period.</p> <p>During an interview on 11/25/24 at 3:14 p.m., registered nurse (RN)-B identified she did the most recent MDS for R27. When RN-B went over the medications for R27, RN-B reviewed medications by what they were used for and not specifically the class of medication. R27's was receiving an antidepressant to help with anxiety, and it was entered on the MDS as an antianxiety medication and not an antidepressant. RN-B stated it was important to ensure the MDS was accurate, so staff had the accurate data to care for R27.</p> <p>During an interview on 11/25/24 at 4:00 p.m., the director of nursing (DON) stated she would expect the MDS for R27 would be complete and accurate to enable others working with R27 to get a complete picture of care required for them.</p> <p>The facility's MDS 3.0 Resident Assessment Instrument (RAI) dated 8/27/24, identified each team member would review the electronic medical record and determine if there is accurate documentation which supported coding for the MDS.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on observation, interview and document review, the facility failed to provide assistance with toileting for 1 of 1 resident (R203) reviewed for activities of daily living and who were dependent on staff for their care.</p> <p>Findings include:</p> <p>R203's admission Minimum Data Set (MDS) dated [DATE], identified R203 had severe cognitive impairment and did not have behaviors. R203 required partial to moderate assistance with eating. R203 was dependent with toileting and transfers and was always incontinent of bowel and bladder. Diagnoses included malignant neoplasm of the sinus and brain, palliative care, moderate protein-calorie malnutrition, and pressure ulcer stage two of the sacral region.</p> <p>R203's care plan dated 10/31/24, identified R203 was dependent with most activities of daily living and was bedfast all or most of the time. R203 was incontinent of bowel and bladder. Staff were directed to check and change every two hours and as needed.</p> <p>During continuous observation on 11/20/24 from 4:30 p.m. to 7:10 p.m., R203 was awake, lying on her back in bed, dressed in a hospital gown. A pillow was positioned under R203's right foot. No other positioning devices were in use. R203's head of the bed was raised at 25-degree angle.</p> <p>-at 4:50 p.m. there was no change in R203's position.</p> <p>-at 5:22 p.m. there was no change in R203's position.</p> <p>-at 5:37 p.m. nursing assistant (NA)-N entered the room to record R203's supper meal choices. NA-N raised R203's head of the bed to a 35-degree angle and asked R203 what she would like for supper. NA-N told R203 she would return with a couple of pudding choices for her supper and then exited the room. NA-N did not check R203 for incontinence.</p> <p>-at 5:45 p.m. licensed practical nurse (LPN)-C entered R203's room and raised the head of the bed to an upright sitting position of 45 degrees. LPN-C administered medications and exited the room. LPN-C did not check R203 for incontinence before exiting the room.</p> <p>-At 5:50 p.m. R203's call light was put on. LPN-C and an unidentified NA entered room. R203 identified the call light was on by accident and nothing was needed. Both staff exited the room after turning off call light. R203 was not checked for incontinence or need for toileting and remained seated fully seated upright in bed.</p> <p>- At 5:57 p.m. R203 turned on her call light. R203 was seated in bed. the head of the bed was in an upright position. R203 had slid down in the bed and her head was hanging heavily to her right side with her chin in her chest.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-At 6:11 p.m. R203 had not changed position. R203's head of the bed remained in full upright position. R203 was in slouched position in bed, leaning to her right side, with her chin in her chest. The call light remained on with steady green light over the door.</p> <p>-At 6:30 p.m. R203 had not changed position, the head of the bed remained in fully upright position. R203 has slouched further down in the bed with her head positioned halfway from top of bed to middle of bed. R203 leaning to her right side with her chin in her chest. The call light remained on.</p> <p>-At 6:45 p.m. there was no change in position.</p> <p>-At 6:56 p.m. R203's head of the bed remained fully elevated at 45-degree angle. R203 was leaning heavily to her right side with her chin touching her chest and slouched down to the middle of the bed. The call light remained on.</p> <p>-At 7:06 p.m. NA-M and NA-N entered R203's room and lowered R203's head of the bed and checked R203 for incontinence. R203 was dry and did not require a brief change.</p> <p>During interview on 11/20/24, at 7:10 p.m. NA-M stated they just checked R203 for incontinence and she was dry. NA-M stated she had been told R203 was checked at 4:30 p.m. NA-M knew R203 needed to be checked and/or changed and repositioned every two hours. NA-M and NA-N were walking by and noticed R203 was leaning so far over to the right and nearly falling out of bed so they went in to reposition her. NA-M noticed R203's light was on and wondered why, which is why she walked down the hall to check.</p> <p>During interview on 11/25/24, at 2:30 p.m. NA-N stated she remembered going into R203's room on 11/20/24 and offering her supper. R203 refused supper but then NA-N offered pudding and R203 had agreed. NA-N stated she had not checked or changed R203 for incontinence at that time.</p> <p>When interviewed on 11/21/24, at 12:05 p.m. the director of nursing stated it was the facility's expectation staff were to check and change residents every two hours if the care plan directed them to do so.</p> <p>The facility policy Activities of Daily Living dated 12/4/23, identified any resident who was unable to carry out activities of daily living would receive necessary services to maintain good nutrition, grooming, personal and oral hygiene.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 1 resident (R203) reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>R203's admission Minimum Data Set (MDS) dated [DATE], identified R203 had severe cognitive impairment and did not have identified behaviors. R203 required substantial to maximum assistance with rolling side to side and sitting up. R203 was dependent with toileting and transfers and was always incontinent of bowel and bladder. R203 was at risk for pressure ulcer development and was admitted with a stage two unhealed pressure ulcer. A turn and reposition program was in place as well as a pressure reducing device for R203's bed. Diagnoses included malignant neoplasm of the sinus and brain, palliative care, moderate protein-calorie malnutrition, and pressure ulcer stage two of the sacral region.</p> <p>R203's care plan dated 10/31/24, identified R203 was dependent with most activities of daily living and was bedfast all or most of the time. R203 had actual impairment to skin integrity. Staff were directed to use extra caution with transfer and bed mobility to avoid injury to R203 skin, keep skin clean and dry and to turn and reposition R203 every two hours and as needed.</p> <p>R203's Braden Skin Assessment 10/31/24, scored 13 which identified a moderate risk for pressure ulcer development.</p> <p>During continuous observation on 11/20/24. 4:30 p.m. to 7:10 p.m. R203 was awake, lying on her back in bed, dressed in a hospital gown. A pillow was positioned under R203's right foot. No other positioning devices were in use. R203's head of the bed was raised at 25-degree angle.</p> <p>-at 4:50 p.m. there was no change in R203's position.</p> <p>-at 5:22 p.m. there was no change in R203's position.</p> <p>-at 5:37 p.m. homemaker (HMK)-A entered the room to record R203's supper meal choices. HMK-A raised R203's head of the bed to a 35-degree angle and exited the room. HMK-A made no attempt to move, shift R203's weight or reposition R203.</p> <p>-at 5:45 p.m. licensed practical nurse (LPN)-C entered R203's room and raised the head of the bed to an upright sitting position of 45 degrees. LPN-C administered medications and exited the room. LPN-C did not turn, shift R203's weight or reposition R203 before exiting the room.</p> <p>-at 5:50 p.m. R203's call light was put on. LPN-C and unidentified NA entered room. R203 indicated the call light was on by accident and nothing was needed. Both staff exited the room after turning off call light. Neither staff attempted to turn, reposition or move R203. R203 remained seated fully upright in bed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 5:57 p.m. R203 turned on her call light. R203 remained seated fully upright in bed. R203 had slid down in the bed and her head was hanging heavily to her right side with her chin in her chest.</p> <p>-at 6:11 p.m. R203 had not changed position. R203's head of the bed remained in full upright position. R203 was in slouched position in bed, leaning to her right side, with her chin in her chest. The call light remained on with steady green light over the door.</p> <p>-at 6:30 p.m. R203 had not changed position. The head of the bed remained in fully upright position. R203 has slouched further down in the bed with her head positioned halfway from top of bed to middle of bed. R203 leaning to her right side with her chin in her chest. The call light remains on.</p> <p>-At 6:45 p.m. there is no change in position.</p> <p>-At 6:56 p.m. R203's head of the bed remained fully elevated at 45-degree angle. R203 was leaning heavily to her right side with her chin touching her chest and slouched down to the middle of the bed. The call light remained on.</p> <p>-At 7:06 p.m. NA-M and NA-N entered R203's room and lowered R203's head of the bed and turned and repositioned R203. R203 was not incontinent of bowel or bladder. R203's peri area had dry, intact skin. Coccyx wound healed with no redness noted. NA-M stated she had been told R203 had been turned and repositioned at 4:30 p.m. NA-M knew R203 was to be checked and/or changed and repositioned every two hours. NA-M and NA-N had been walking by and noticed R203 was leaning so far over to the right and nearly falling out of bed, so they went in to reposition her. NA-M had noticed R203's light was on, and she had wondered why, which is why she walked down the hall to check.</p> <p>When interviewed on 11/21/24, at 12:05 p.m. the director of nursing stated it was the facility's expectation staff were to check and change residents every two hours if the care plan directed them to do so. The long call wait time would need to be looked in to.</p> <p>The facility policy Activities of Daily Living dated 12/4/23, identified any resident who was unable to carry out activities of daily living would receive necessary services to maintain good nutrition, grooming, personal and oral hygiene.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on interview and document review, the facility failed to comprehensively assess for trauma informed care to identify potential triggers and avoid potential re-traumatization for 1 of 1 resident (R22) reviewed who had a history of trauma.</p> <p>Findings include:</p> <p>R22's quarterly Minimum Data Set (MDS) dated [DATE], identified R22 had moderate cognitive impairment and exhibited behavior of verbal abuse to others four to six times per week and physical behaviors of hitting, scratching, pacing and wandering, one to three times per week. R22 also rejected care four to six times weekly. Diagnoses included chronic myeloid leukemia, anxiety, post traumatic stress disorder (PTSD) and dementia.</p> <p>R22's care plan with last revision date 10/11/24, identified R22 had impaired cognition and impaired thought process as well as behavior symptoms of hitting staff, name calling, throwing objects, sexual comments and unpredictable behaviors related to impaired cognition, anxiety and PTSD. Interventions included approach with soft tone of voice, let him know comments are inappropriate, redirect, use humor, divert attention about talking about his home or grandchildren. However, R22's care plan lacked individualized trauma-informed approaches or interventions and identification of triggers to avoid potential re-traumatization.</p> <p>R22's order summary report dated 11/21/24, identified R22 received Depakote 125 milligrams (mg) two times per day for post traumatic stress disorder.</p> <p>R22's telehealth psychiatric visit note dated 8/12/24, identified R22 had PTSD and a family member identified R22 served in the Vietnam war and had flashbacks of the war.</p> <p>R22's medical record lacked a comprehensive assessment for R22's PTSD, potential triggers and interventions.</p> <p>When interviewed on 11/19/24, at 1:00 p.m. family member (FM)-A reported R22 served in Vietnam and had a career as a fire chief. R22 had taken care of dismembered people and traumatic injuries that never seemed to bother him; however, R22 was taking the medication Depakote for PTSD.</p> <p>A joint interview was conducted with nursing assistant (NA)-B and trained medication assistant (TMA)-A on 11/20/24 at 2:00 p.m NA-B stated when she talked with R22 he would bring up his service and mention how he was near others who got blown up and/or how his general treated him. R22 did not seem anxious or upset when discussing these things with her. NA-B see how R22 could get upset with certain people depending on how R22 was spoken to. TMA-A stated he knew R22 would get angry if others mentioned they were in the service but did not serve in war. R22 would comment to them they did not know anything if they had not been in war and make angry comments.</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 11/21/24, at 8:15 a.m. registered nurse (RN)-C stated the diagnosis of PTSD should be assessed and care planned. R22's was not assessed or have a care plan related to R22's PTSD. It would be important to have the PTSD addressed on R22's plan of care to alert staff to what his triggers were.</p> <p>During interview on 11/21/24, at 12:00 p.m. the director of nursing stated it would be important to assess and care plan a diagnosis of PTSD with interventions for staff to avoid known triggers, if any.</p> <p>On 11/24/24, at 10:45 a.m. R22 was observed sitting in recliner in his room fully dressed and watching television. R22 stated he had lost several of his fingers during a work accident while working at the local paper mill. R22 stated he served three years in Vietnam and then was the local fire chief and ran the fire department for the town in which he lived for many years before he eventually retired. R22 did not elaborate on his service in Vietnam or the fire department.</p> <p>The facility policy Trauma Informed Care dated 11/16/23, identified a trauma assessment was required within five days of admission and as needed. The interview would focus on understanding the resident's experience. Staff were directed to document how trauma was currently affecting the resident. Individualized care plan interventions were required to avoid re-traumatization.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>40943</p> <p>Post nurse staffing information every day.</p> <p>Based on observation, interview and document review, the facility failed to consistently post the census on the nurse staff posting; failed to identify when the posting changed due to call ins; and failed to retain the nurse staff posting for 18 months. This had the potential to affect all 50 residents residing in the facility and/or visitors who may wish to view the information.</p> <p>Findings include:</p> <p>During an observation on 11/19/24 at 7:09 a.m., the staff posting was in a display case at the front entrance at the persons in charge list. The posting was dated Friday 11/15/24, and identified the census was 51 and listed the following staff scheduled working hours per shift for each nursing job class. However, the posting failed to identify the staff actually worked hours due to call-ins, vacations and/or staff shortages. The facility provided a print out that reflected staff timecard punches, however, an actual working staff schedule that reflected call-ins, staff shortages and/or vacations was requested, but not received.</p> <p>The nurse staff postings dated 10/8/24 through 11/15/24, were reviewed and identified the following dates were missing: 10/9/24 through 10/16/24, 10/18/24 through 10/20/24, 10/22/24, 10/25/24 through 10/27/24, 11/2/24, 11/3/24, 11/7/24, 11/9/24 through 11/12/24. Additionally, the nurse staff postings failed to identify if corrections had been completed to reflect staffing changes, including call ins.</p> <p>During an interview on 11/20/24 at 9:55 a.m., household coordinator (HC)-A stated she was responsible for the staff schedule and the nurse staff posting. HC-A posted the nurse staff posting in the display case at the front entrance Monday through Thursday when she was at the facility. HC-A printed the nurse staff posting on Thursday for the weekend and the charge nurse was responsible to post it. HC-A stated the facility had consistent staff shortages, especially on the evening shift. HC-A stated she had never thought of updating the nurse staff posting to reflect call-ins and/or changes in staffing numbers and was unsure how long the nurse staff postings should be retained, possibly a year.</p> <p>During an interview on 11/25/24 at 2:01 p.m., the director of nursing (DON) stated the nurse staff posting should be kept for 18 months and should be posted daily. The DON stated she was unaware the nurse staff posting should be updated to show changes in actual working staff, but it would allow residents and visitors to determine numbers of staff in the building.</p> <p>During an interview on 11/25/24 at 2:28 p.m., the administrator stated his expectation was have the census recorded and posted daily on the nurse staff posting form.</p> <p>A policy regarding the nurse staff posting was requested but not received.</p>		

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NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - International Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 Keenan Drive International Falls, MN 56649	
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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on interview and document review, the facility failed to ensure the consulting pharmacist (CP) identified and communicated to the facility the need for monitoring for potential adverse events for high- risk medications for 2 of 5 residents (R22, R37); and failed to identify the need to monitor for adverse behaviors for psychotropic medications for 1 of 5 residents (R37) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R22's quarterly Minimum Data Set (MDS) dated [DATE], identified R22 had moderate cognitive impairment and exhibited behavior of verbal abuse to others four to six times per week and physical behaviors of hitting, scratching, pacing, and wandering, one to three times per week. R22 also rejected care four to six times weekly. The MDS identified R22 had received antidepressant medications daily. Diagnoses included chronic myeloid leukemia, anxiety, post-traumatic stress disorder (PTSD) and dementia.</p> <p>R22's signed Order Summary Report, dated 11/21/24, identified R22's current ordered medications and treatments at the nursing home. These included orders for: Gleevec (to treat myeloid leukemia) 400 milligrams (mg) daily, nurse to monitor for side effects and MD as needed, and venlafaxine (to treat depression) 75 mg daily. The summary listed an order which directed Nurse to monitor for the following symptoms: weakness, dizziness, sudden changes in strength or mobility, nausea or vomiting, unusual bleeding, bruising, black or tarry stools, extreme fatigue. Swelling, redness and/or pain in upper or lower extremities, yellowing of the skin or eyes, swelling of the face, mouth, tongue, legs, ankles or feet, or sudden weight gain.</p> <p>R22's medical record lacked evidence R22 was being assessed or evaluated for adverse effects as ordered by the physician.</p> <p>R22's PharMerica Physician Recommendations dated 8/23/24, identified R22 was receiving venlafaxine and donepezil daily. The consultant pharmacist (CP) identified donepezil could cause side effects for aggression and agitation. A recommendation was made to increase venlafaxine and consider reducing R22's donepezil.</p> <p>During interview on 11/21/24, at 11:11 a.m. registered nurse (RN)-C stated R22 did have an active order to monitor for side effects to his chemotherapy medication and so the order should be on his MAR to monitor. The MAR usually pulled from the resident orders but in R22's case, it had been entered incorrectly and did not get pulled over. It was the facility policy to monitor high risk medication and psychotropic medications for side effects every shift and document it was completed on the MAR or the TAR. RN-C had just discussed the need to monitor labs with residents on certain medications. Lab work was not part of the standing orders, and they relied on the primary physician to order labs as needed and so it frequently was missed.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Pharmacy reviews were conducted monthly and review of recommendations January 2024 through November 2024, identified no further concerns or recommendations. The pharmacy reviews lacked evidence the CP identified the need and made the recommendation to the facility to monitor for psychotropic medication adverse effects as ordered.</p> <p>R37's quarterly MDS dated [DATE], identified R37 had intact cognition and no behavioral symptoms were identified. The MDS indicated R37 had consumed antidepressant, anticoagulant and diuretic medications daily. Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety, atrial fibrillation (irregular heartbeat), and kidney disease.</p> <p>R37's signed Order Summary Report, dated 11/25/24, identified R37's current physician ordered medications and treatments at the nursing home. These included orders for furosemide (a diuretic) 40 mg daily, lorazepam (an antianxiety) 0.5 mg at bedtime, methimazole (to treat hyperthyroid) 2.5 mg daily and Lexapro (an antidepressant) 10 mg daily.</p> <p>A hospital discharge summary dated 11/28/23, identified R37 had been hospitalized and treated for anemia with a hemoglobin of 6.4. R37's hemoglobin on discharge was 10.3 and medications changes were made to discontinue coumadin and to start aspirin 325 mg instead.</p> <p>R37's medical record lacked evidence R22 had annual blood work to assess, or evaluate for adverse effects, effectiveness of hyperthyroid treatment and monitoring for therapeutic dosages.</p> <p>R37's PharMerica Physician Recommendations dated 7/29/24, identified R37 received Lexapro and lorazepam daily with a recommendation to the physician to review the medications and consider a gradual dose reduction (GDR). The physician refused the recommendation due to R37 was stable with current dose.</p> <p>Pharmacy reviews were conducted monthly and review of recommendations January 2024 through November 2024, identified no further concerns or recommendations. The pharmacy reviews lacked evidence the CP identified the need and made the recommendation to the facility to monitor for psychotropic medication side effects as ordered or to track and monitor adverse behaviors for which the medications were ordered.</p> <p>During interview on 11/21/24, at 11:11 a.m. RN-C stated R37 should have had lab work done to monitor for dehydration related to her diuretic medications as well as potassium level and hemoglobin to check for the need for supplementation related to the diuretic medications. RN-C had just discussed this with the director of nursing (DON) that some residents should have routine lab work done every six months to a year. Some of the physicians were on top of their residents to order labs and others were not.</p> <p>A joint interview was conducted with the DON and RN-D on 11/21/24, at 11:59 a.m. RN-D stated it was the facility's practice to monitor high risk and psychotropic medications every shift and staff were to document it was completed on the resident's TAR. The DON stated R37 should have symptoms of anxiety and depression monitored every shift. RN-D stated they never received recommendations from the pharmacist regarding need for lab work related to a resident's medications. RN-D commented it would be another check to ensure things were not missed and a good resource for the facility.</p> <p>(continued on next page)</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During telephone interview on 11/25/24, at 3:49 p.m. the CP stated when charts were reviewed monthly the CP did check to ensure the facility was monitoring for side effects as well as adverse behaviors. The facility had been short staffed and had just resumed monthly behavior meetings, which the CP attended. The CP had been looking at each residents' charts for side effects and behavior monitoring and had told the facility to be sure to have specific behaviors to monitor on residents receiving psychotropic medications. The CP had made recommendations to try to reduce medications but felt the recommendations were not considered because the psychiatric clinic would keep adding on more medications. The CP felt R37 should have some lab work drawn. Sometimes the resident or family would refuse but the CP was unsure why a recommendation to check lab work was not made for R37.</p> <p>The facility policy Consultant Pharmacist Services Provider Requirements dated 1/2023, identified regular and reliable pharmacist services were to be provided to residents of the facility. The consultant pharmacist would provide pharmaceutical care services.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on interview and document review, the facility failed to ensure adverse event monitoring was completed for high-risk medications 2 of 5 residents (R22, R37) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R22's quarterly Minimum Data Set (MDS) dated [DATE], identified R22 had moderate cognitive impairment. Diagnoses included chronic myeloid leukemia and dementia.</p> <p>R22's signed Order Summary Report, dated 11/21/24, identified R22's current ordered medications and treatments at the nursing home. These included orders for: Gleevec (to treat myeloid leukemia) 400 milligrams (mg) daily, nurse to monitor for side effects and notify MD as needed. The summary listed an order which directed Nurse to monitor for the following symptoms: weakness, dizziness, sudden changes in strength or mobility, nausea or vomiting, unusual bleeding, bruising, black or tarry stools, extreme fatigue. Swelling, redness and/or pain in upper or lower extremities, yellowing of the skin or eyes, swelling of the face, mouth, tongue, legs, ankles or feet, or sudden weight gain.</p> <p>R22's care plan dated 10/11/24, identified R22 consumed a non-cytotoxic oral chemotherapy with a goal to remain free of complications related to chemo therapy side effects. Interventions included drawing blood work as ordered, administering the medication as ordered, and monitor for chemotherapy complications and side effects.</p> <p>R22's Medication Administration Record (MAR), dated 11/2023, identified the order for Gleevec and recorded R22 received the medication, as ordered, on a daily basis. However, the MAR and Treatment Administration Record (TAR) both lacked evidence of monitoring for adverse effects of the medications. Further, R22's medical record was reviewed and lacked evidence R22 was being assessed, or evaluated for adverse effects as ordered by the physician.</p> <p>During interview on 11/21/24, at 11:11 a.m. registered nurse (RN)-C stated R22 did have an active order to monitor for side effects to his chemotherapy medication and so the order should be on his MAR or TAR to monitor. The MAR usually pulled from the resident orders but in R22's case, it had been entered incorrectly and did not get pulled over. It was the facility policy to monitor high risk medication for side effects every shift and document it was completed on the TAR. RN-C had just discussed the need to monitor labs with residents on certain medications. Lab work was not part of the standing orders and they relied the primary physician to order labs as needed and so it frequently was missed.</p> <p>R37's quarterly MDS dated [DATE], identified R37 had intact cognition and no behavioral symptoms were identified. The MDS indicated R37 had consumed anticoagulant and diuretic medications daily. Diagnoses included chronic obstructive pulmonary disease (COPD), atrial fibrillation (irregular heartbeat), and kidney disease.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R37's signed Order Summary Report, dated 11/25/24, identified R37's current physician ordered medications and treatments at the nursing home. These included orders for furosemide (a diuretic) 40 mg daily, potassium (a supplement) 10 milliequivalents daily, and methimazole (to treat hyperthyroid) 2.5 mg daily.</p> <p>R37's care plan with last revision date 8/13/24, identified R37 received diuretic therapy. Interventions included monitor for side effects based on clinical standards of practice and to monitor for symptoms of dehydration and encourage adequate fluid intake.</p> <p>R37's medical record lacked evidence annual lab work was completed to monitor for adverse effects and/or therapeutic drug levels of the high risk medications.</p> <p>R37's MAR, dated 11/2023, identified the orders for furosemide, methimazole and potassium and recorded R37 received the medications, as ordered, on a daily basis. However, the MAR and TAR both lacked evidence staff were monitoring for adverse effects of the medications. Further, R37's medical record was reviewed and lacked evidence R22 had annual blood work to assess, or evaluate for adverse effects, effectiveness of hyperthyroid treatment and monitoring for therapeutic dosages.</p> <p>During interview on 11/21/24, at 11:11 a.m. registered nurse RN-C stated R37 should have had lab work done to monitor for dehydration related to her diuretic medications as well as potassium level and hemoglobin to check for the need for supplementation related to the diuretic medications and history of anemia. RN-C had just discussed this with the DON that some residents should have routine lab work done every six months to a year. Some of the physicians were on top of their residents to order labs and others were not.</p> <p>During joint interview on 11/21/24, at 11:59 a.m. with the director of nursing and RN-D, RN-D stated it was the facility's practice to monitor for adverse events with high risk medications every shift and staff were to document it was completed on the resident's TAR.</p> <p>During telephone interview on 11/25/24, at 3:49 p.m. the consultant pharmacist (CP) stated when charts were reviewed monthly the CP did check to ensure the facility was monitoring for side effects. The CP reviewed each resident charts individually for side effects. When a resident was receiving diuretic or thyroid medications, lab work was something the facility would want to look at. R37 should have lab work drawn and the CP was not sure why there had not been a recommendation to do so in the past year.</p> <p>The facility policy Medication Drug Regimen Review dated 2/28/24, identified the drug regimen review was a process that included medication reconciliation and review of all medications a resident was taking to identify and prevent potentially significant medication issues.</p> <p>A policy to monitor for side effects of medications was requested, however, none was received.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on interview and document review, the facility failed to ensure adverse event monitoring was completed for 2 of 5 residents (R22, R37); and failed to monitor adverse behaviors for 1 of 5 residents (R37) reviewed for unnecessary medication use and were taking a psychotropic medication.</p> <p>Findings include:</p> <p>R22's quarterly Minimum Data Set (MDS) dated [DATE], identified R22 had moderate cognitive impairment and exhibited behaviors of verbal abuse to others four to six times per week and physical behaviors of hitting, scratching, pacing and wandering, one to three times per week. R22 also rejected care four to six times weekly. The MDS identified R22 had received antidepressant medications daily. Diagnoses included chronic myeloid leukemia, anxiety, post-traumatic stress disorder (PTSD) and dementia.</p> <p>R22's signed Order Summary Report, dated 11/21/24, identified R22's current ordered medications and treatments at the nursing home. These included orders for: venlafaxine (to treat depression) 75 mg daily. The summary listed an order which directed Nurse to monitor for the following symptoms: weakness, dizziness, sudden changes in strength or mobility, nausea or vomiting, unusual bleeding, bruising, black or tarry stools, extreme fatigue. Swelling, redness and/or pain in upper or lower extremities, yellowing of the skin or eyes, swelling of the face, mouth, tongue, legs, ankles or feet, or sudden weight gain.</p> <p>R22's care plan dated 10/11/24, included interventions of report to nurse signs and symptoms of confusion, mood change, change in behavior, or ability to help with activities of daily living, suicidal ideation, constipation, shuffle gait, rigid muscles, diarrhea, appetite loss, weight loss, nausea and vomiting and fatigue.</p> <p>R22's Medication Administration Record (MAR), dated 11/2023, included the order for venlafaxine and identified R22 received the medication, as ordered, on a daily basis. However, the MAR and Treatment Administration Record (TAR) lacked evidence of an order to monitor for adverse effects of the medications.</p> <p>R22's medical record lacked evidence R22 was being assessed or evaluated for adverse effects as ordered by the physician.</p> <p>During interview on 11/21/24, at 11:11 a.m. registered nurse (RN)-C stated R22 did have an active order to monitor for side effects and so the order should be on the resident's MAR or TAR to monitor. The MAR and TAR usually pulled from the resident orders but in R22's case, it had been entered incorrectly and did not get pulled over. It was the facility policy to monitor high risk psychotropic medications for side effects every shift and document it was completed on the TAR.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R37's quarterly MDS dated [DATE], identified R37 had intact cognition and no behavioral symptoms were identified. The MDS indicated R37 received antidepressant, and antianxiety medications daily. Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety, atrial fibrillation (irregular heartbeat), and kidney disease.</p> <p>R37's signed Order Summary Report, dated 11/25/24, identified R37's current physician ordered medications and treatments at the nursing home. These included orders for lorazepam (an antianxiety) 0.5 mg at bedtime, and Lexapro (an antidepressant) 10 mg daily.</p> <p>R37's care plan with last revision date 8/13/24, identified R37 had depression and included interventions to help R37 meet this goal including consult with pharmacist, administer the medication as ordered, and monitor for complications and side effects such as confusion, mood change, change in behavior, or ability to help with activities of daily living, suicidal ideation, constipation. Staff were also directed to monitor and report if noted increased anger, labile mood or agitation, feeling threatened or thoughts of harming others, and possession of objects that could be used for weapons.</p> <p>R37's MAR dated 11/2023, identified the orders for lorazepam and Lexapro and recorded R37 received the medications, as ordered, on a daily basis. However, the MAR and TAR lacked evidence staff monitored for adverse effects of the medications. The MAR and TAR failed to identify behavioral symptoms to monitor, and track.</p> <p>R37's medical record lacked evidence R37's behaviors were monitored, assessed, and reviewed to justify the daily medication administration.</p> <p>During joint interview on 11/21/24, at 11:59 a.m. with the director of nursing (DON) and RN-D, RN-D stated it was the facility's practice to monitor psychotropic medications every shift and staff were to document it was completed on the resident's TAR. The DON stated R37 should have symptoms of anxiety and depression monitored every shift.</p> <p>During telephone interview on 11/25/24, at 3:49 p.m. the consultant pharmacist (CP) stated when charts were reviewed monthly the CP did check to ensure the facility was monitoring for side effects as well as adverse behaviors. The facility had been short staffed and had just resumed monthly behavior monitoring meetings. During the meetings the facility staff and CP reviewed each residents' psychotropic medications and behavior monitoring. The CP also looked at each resident's chart individually and had made the recommendation to be sure to have specific individualized targeted behaviors for each resident and not just general. The CP was working on reviewing psychotropic medications and behavior monitoring and had planned to review the wing where R37 and R22 resided later in the week. She was not sure why she had not made recommendations to monitor side effects for the two residents or adverse behaviors for R37. Those were things the CP reviewed when she reviewed the resident charts monthly.</p> <p>The facility policy Psychotropic Medications dated 12/6/23, identified throughout the administration of psychotropic medications, mood and behavior documentation must continue in order to monitor the effect the medication has on the behaviors, as well as monitoring for side effects. Staff were directed to monitor for effectiveness and potential adverse consequences of the medications.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943</p> <p>Based on observation, interview and document review, the facility failed to ensure two insulin pens were labeled with the resident name for 1 of 1 resident (R154) observed to receive insulin.</p> <p>Findings include:</p> <p>R154's Admission Record dated 11/25/24, identified R154 was admitted to the facility on [DATE].</p> <p>R154's Diagnosis Report dated 11/25/24, identified R154 was a Type 2 diabetic.</p> <p>R154's Order Summary Report dated 11/25/24, identified the following:</p> <p>11/13/24, R154 was prescribed insulin lispro (Humalog) (a short acting insulin) with the following instructions: - insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 unit/milliliter (ml) Inject as per sliding scale: if 0 - 160 = 0 UNITS; 161 - 190 = 1 UNIT; 191 - 220 = 2 UNITS; 221 - 250 = 3 UNITS; 251 - 280 = 4 UNITS; 281 - 310 = 5 UNITS; 311 - 340 = 6 UNITS; 341 - 370 = 7 UNITS; 371 - 400 = 8 UNITS; 401 - 999 = 9 UNITS, subcutaneously three times a day for Type 2 diabetes. Give sliding scale dose in addition to scheduled dose. - Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML give 25 Units before breakfast daily plus sliding scale; give 22 Units before lunch daily plus sliding scale; and give 21 Units before supper daily plus sliding scale.</p> <p>- 11/13/24, R154 was prescribed Toujeo Max SoloStar Subcutaneous Solution Pen-injector 300 unit/ml (insulin glargine) (a long acting insulin) inject 84 unit subcutaneously one time a day for Type 2 diabetes.</p> <p>During an observation on 11/19/24 at 8:59 a.m., licensed practical nurse (LPN)-A administered Humalog insulin and Toujeo to R154. Neither the Humalog kwik pen or the Toujeo pen had a label identifying the pens belonged to R154.</p> <p>During an interview on 11/19/24 at 9:02 a.m., LPN-A stated the medication pens did not come with a label from the pharmacy but the boxes did. The boxes of medication were kept in the fridge in the medication room. When asked how she knew the pens belonged to R154, LPN-A stated R154 was the only diabetic resident on the unit who received injectable medication. The medication pens were stored in the top drawer of the medication cart and everyone just knew they belonged to R154. I guess I could put her [R154] initials and room number on it.</p> <p>During an interview on 11/19/24 at 9:22 a.m., registered nurse (RN)-A stated all medication pens should be labeled when they come from the pharmacy. If not, staff should put a sticker with the resident's information on it. RN-A stated she was unaware R154's medication pens were unlabeled but would put a sticker on them. There was only one diabetic resident on the unit and R154 was just admitted to the facility on [DATE]. RN-A stated a medication pen without a label was an infection control issue because staff shouldn't use a medication pen on the wrong resident. Also, R154 paid for that medication, and it should be labeled with R154's name.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/25/24 at 3:44 p.m. the director of nursing (DON) stated she expected all medication pens to come from the pharmacy labeled or staff should place a resident sticker on the pen identifying who the pen belonged to.</p> <p>The facility policy Medication Ordering and Receiving from Pharmacy Provider Medications and Medication Labels dated 1/2023, identified each prescription medication would be labeled to include:</p> <ul style="list-style-type: none"> a. Resident's name b. Specific directions for use, including route of administration c. Medication name d. Strength of medication e. Prescriber's name f. Date medication is dispensed g. Quantity dispensed h. Expiration or end-of-use date, if not dispensed in original manufacturer packaging i. Name, address, and telephone number of dispensing pharmacy J. Prescription number k. Accessory/precautionary labels indicating storage requirements and special procedures. Example: Shake well, Take on empty stomach, one hour before or 2 hours after meals, Do not crush. l. Dispensing pharmacist's initials m. Lot number of medication dispensed, if not dispensed in original manufacturer packaging, where required by state law n. Any other information required by state and federal <p>Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the dispensing pharmacy for re-labeling or destroyed in accordance with the medication destruction policy.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245318	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on interview and document review the facility failed to review and update the facility assessment to incorporate the minimal staff requirements; and all resources and conditions to care for the resident populations. This had the potential to affect all 50 residents who resided in the facility.</p> <p>Findings include:</p> <p>The Facility assessment dated [DATE], identified the need to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies. The assessment listed resident count, activities of daily living (ADL) assistance needed, behavioral symptoms and active diagnoses. The facility utilized an interdisciplinary approach to meet the needs of residents across all shifts, including nights and weekends. The scheduler would check the schedule and divide staff based on the acuity of the facility assessment. The facility assessment failed to include information on the staffing levels needed for specific shifts, such as day, evening, and nights based on resident population and acuity. The facility assessment failed to identify residents who required oxygen supplementation and identify the minimal equipment and supplies needed to care for oxygen dependent residents. The facility assessment lacked evidence of assessment of resident population with diagnosis of PTSD.</p> <p>During interview on 11/25/24, at 2:10 p.m. the administrator stated the facility assessment had been completed by the previous administrator and he had not reviewed the assessment. Minimum staffing was based on the facility census. The bare minimum staffing would be one nurse and aide on each wing during the day and evening shift and one aide on each wing and a nurse float for the overnight shift. There should be something in the facility assessment that addressed minimum staffing needs. The administrator was unsure how detailed oxygen needs of residents would need to be documented in the facility assessment, but he was aware PTSD was required to be covered in the assessment.</p> <p>A policy on the facility assessment was required, however none was received.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>41575</p> <p>Based on interview and document review, the facility failed to develop action plans for identified areas of monitoring and failed to identify and implement at least one process improvement project (PIP) This had the potential to affect all 50 residents who resided in the facility.</p> <p>Findings include:</p> <p>The Quality Assurance, Action Committee Meeting Minutes dated 7/11/24, identified the team had reviewed the following topics:</p> <ul style="list-style-type: none"> -infection control. -emergency operation plan and facility assessment. -dietary concerns -therapy staffing changes -documentation of assessments and coding -resident council complaints -life style enrichment -human resources -life safety and environment <p>The data failed to identify any facility developed and implemented action plans with measurable goals and/or identify actions taken.</p> <p>The Quality Assurance, Action Committee Meeting Minutes dated 8/22/24, identified the team had reviewed the following topics:</p> <ul style="list-style-type: none"> -nursing services -resident council complaints -safety and emergency preparedness -employee action committee results -financial stewardship, <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-action plans from survey, [NAME] reports and/or corporate compliance.</p> <p>The data failed to identify any facility developed and implemented action plans with measurable goals and/or identify actions taken.</p> <p>The Quality Assurance, Action Committee Meeting Minutes dated 10/31/24, identified the team had reviewed the following topics:</p> <ul style="list-style-type: none"> -incidents and safety -infection control -medication regimen review -QAPI plan priorities -staff quality concern trends -hand hygiene compliance -survey readiness -resident and family concerns -survey results <p>The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken.</p> <p>Although the facility listed out areas they were collecting data on there was a lack of information on whether the items were PIPS that required an action plan. Further, the facility could not provide evidence of any PIP project they were working on that focuses on high-risk or problem-prone areas, identified by the facility through data collection and analysis.</p> <p>When interviewed on 11/25/24, at 4:15 p.m. registered nurse (RN)-D stated she was responsible for the facility's QAPI program. RN-D received monthly audits from corporate and the facility was required to do them. Each month the audits would have a different focus. RN-D also gathered data for QAPI through focused chart reviews and track and analyzing incident reports. RN-D had social services report complaints and grievances to the QAPI committee as well. RN-D also collected data from review of resident council minutes and interactions with residents and families on a day-to-day basis. The facility did have significant issues with staffing in the beginning of the year and the main focus had been on staffing and staff retention. Now that had improved, and they could focus on other issues. Infection control and review of infections were addressed at every QAPI meeting; however, RN-D had not fully addressed the facility's response to their recent COVID-19 outbreak. That was on her agenda to discuss at the next meeting. RN-D stated performance improvement projects (PIPS) were new to her. She had just taken over QAPI and had not received much training on PIPS. RN-D was just trying to redirect everything in a format she could work with, and her next project was to figure out what type of PIP to work on. RN-D stated she needed to learn how to do the PIPS.</p> <p>(continued on next page)</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on 11/25/24, at 4:30 p.m. the director of nursing (DON) stated RN-D ran the QAPI program. The DON was not aware the facility did not have any developed PIPS in place. The DON stated there should be performance improvement projects in place and she would have helped identified areas to implement PIPS if she had been aware there were none.</p> <p>The facility's Quality Assurance and Performance Improvement policy dated 10/9/23, identified at a minimum one performance improvement project would either be in development, ongoing or completed annually utilizing the improvement model adapted by the location. Performance improvement project activity would be monitored for progress and sustainability. Performance improvement activities would focus on high risk, high volume, or problem prone areas. Would consider incidence, prevalence, and severity of problems in that area and would lead to immediate correction of any identified problem that directly or potentially threatened the health and safety of residents. The QAPI committee was responsible for tracking and trending performance, systematically analyzing and prioritizing quality deficiencies, develop action plans, and monitor for effectiveness and sustainability.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943</p> <p>Based on observation, interview and document review, the facility failed to develop and implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting infections and communicable disease along with a monthly analysis; and failed to conduct COVID-19 testing of staff and residents per Centers for Disease Control (CDC) guidelines. In addition, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 1 resident (R205) reviewed with pressure ulcers; and failed to wear a mask during a peripherally inserted central catheter (PIIC) line dressing change for 1 of 1 resident (R206) reviewed with a PIIC. These deficient practices had the potential to affect all 50 residents residing in the facility.</p> <p>Findings include:</p> <p>Surveillance and Analysis:</p> <p>The Monthly Report of Resident Infections in Location dated August 2024, identified unit, resident name, room number, admitted, infection type, body system, criteria met yes or no, onset C (community) or F (facility), symptoms, onset date, infection risk factors, precautions type and date resolved. The report identified two COVID-19 cases, one dental abscess, one conjunctivitis (pink eye), one case of shingles, one pneumonia, three cellulitis, two osteomyelitis (bone infection), eight urinary tract infections (UTI) and one resident without an identified infection who demanded antibiotic drops. However, the report failed to identify if the infections were provided treatment, if any, nor did the report identify a resident with symptoms of a viral infection.</p> <p>The Monthly Infection Summary dated August 2024, identified all identified infections received treatment with an antimicrobial.</p> <p>The Monthly Infection Control Report dated August 2024, identified the total number of infections, the infection rate (infections/1000 resident days), antibiotic orders utilization (orders/1000 resident days) and antibiotic days of therapy (days of therapy/1000 resident days). For the month of August the following information was listed:</p> <ul style="list-style-type: none"> - total number of nosocomial (healthcare acquired) infections 14 - infection rate: 8.85 percent (%) - antibiotic orders utilization: 13.28% - antibiotic days of therapy: 119.5 ordered, 114.5 actual <p>The August 2024 Infection Control Reports identified the facility had 17 infections (14 facility acquired and 3 community acquired), 14 met McCreer's Criteria, 3 did not meet McCreer's Criteria and the facility antimicrobial usage rate was higher than the enterprise as a whole (13.28% versus 5.92%).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Monthly Report of Resident Infections in Location dated September 2024, identified unit, resident name, room number, admitted , infection type, body system, criteria met yes or no, onset C (community) or F (facility), symptoms, onset date, infection risk factors, precautions type and date resolved. The report identified two eye infections, three cases of COVID-19, two cellulitis and one chronic obstructive pulmonary disease (COPD) exacerbation. However, the report failed to identify if the infections were provided treatment, if any nor did the report identify a resident with symptoms of a viral infection other than COVID-19.</p> <p>The Monthly Infection Summary dated September 2024, identified all but three cases of COVID-19 received antimicrobial treatment.</p> <p>The Monthly Infection Control Report dated September 2024, identified the total number of infections, the infection rate (infections/1000 resident days), antibiotic orders utilization (orders/1000 resident days) and antibiotic days of therapy (days of therapy/1000 resident days). For the month of August the following information was listed:</p> <ul style="list-style-type: none"> - total number of nosocomial (healthcare acquired) infections: 7 - infection rate: 5.3% - antibiotic orders utilization: 3.3% - antibiotic days of therapy: 27.9 <p>The September 2024 Infection Control Reports identified the facility had 17 infections (14 facility acquired and 3 community acquired), 14 met McGreer's Criteria, 3 did not meet McGreer's Criteria and the facility antimicrobial usage rate was higher than the enterprise as a whole (33.2% versus 17.6%).</p> <p>The facility failed to provide a written summary of the analysis of actual/potential infections in the facility.</p> <p>The Monthly Report of Resident Infections in Location dated October 2024, identified unit, resident name, room number, admitted , infection type, body system, criteria met yes or no, onset C (community) or F (facility), symptoms, onset date, infection risk factors, precautions type and date resolved. The report identified nine cases of COVID-19, one cellulitis, one pneumonia, and four UTI. However, the report failed to identify if the infections were provided treatment, if any nor did the report identify a resident with symptoms of a viral infection other than COVID-19.</p> <p>The Monthly Infection Summary dated October 2024, identified all but the cases COVID-19 received antimicrobial treatment.</p> <p>The Monthly Infection Control Report dated October 2024, identified the total number of infections, the infection rate (infections/1000 resident days), antibiotic orders utilization (orders/1000 resident days) and antibiotic days of therapy (days of therapy/1000 resident days). For the month of August the following information was listed:</p> <ul style="list-style-type: none"> - total number of nosocomial (healthcare acquired) infections: 17 <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- infection rate: 11.22%</p> <p>- antibiotic orders utilization: 6.6%</p> <p>- antibiotic days of therapy: 38.9</p> <p>The September 2024 Infection Control Reports identified the facility had 17 infections (14 facility acquired and 3 community acquired), 14 met McGreer's Criteria, 3 did not meet McGreer's Criteria and the facility antimicrobial usage rate was lower than the enterprise as a whole (5.4% versus 8.85%).</p> <p>The facility failed to provide a written summary of the analysis of actual/potential infections in the facility.</p> <p>The Monthly Report of Resident Infections in Location dated November 2024, identified unit, resident name, room number, admitted, infection type, body system, criteria met yes or no, onset C (community) or F (facility), symptoms, onset date, infection risk factors, precautions type and date resolved. The report identified two COVID-19 cases, three cellulitis, one osteomyelitis (bone infection), and three urinary tract infections (UTI). However, the report failed to identify if the infections were treated with an antimicrobial.</p> <p>No further information for November 2024 was provided.</p> <p>During an interview on 11/19/24 at 12:57 p.m., registered nurse (RN)-D stated she was responsible for the facility's Infection Prevention Program. RN-D reviewed antibiotics ordered and rounds/observation of what the staff were doing, including hand hygiene audits. RN-D updated the surveillance log everyday Monday through Friday. At the end of the month, RN-D completed all the reports that were needed for Quality Assurance. RN-D did not usually list residents with cold symptoms and/or sniffles on the surveillance log. Now that you say that I should be tracking it.</p> <p>During an interview on 11/21/24 at 3:06 p.m., the DON stated the facility needed to create a better tracking system to track staff and resident illness to prevent the transmission of illness.</p> <p>A facility policy related to infection surveillance, tracking and trending was requested but not received.</p> <p>STAFF TESTING</p> <p>The Centers for Disease Control (CDC) website Infection Control Guidance: SARS-CoV-2 (COVID-19) dated 6/24/24, identified a single new case of COVID-19 infection in any health care provider (HCP) or resident should be evaluated to determine if others in the facility could have been exposed. Perform testing for all residents and HCP identified as close contacts or on the affected unit. Testing was recommended at day 1, day 3 and day 5, where day of exposure is day 0. If additional cases were identified, testing should continue on affected units or facility-wide every 3 to 7 days until there were no new cases for 14 days.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A facility untitled spreadsheet dated 6/18/24 through 11/14/24, identified employee name, positive test date, symptoms onset date, last day worked, unit(s) assigned/worked, precautions (return to work (RTW) dated and instructions) and symptoms. The spread sheet identified nine employees with onset positive dates which included: nursing assistant (NA)-C on 9/28/24, NA-D on 10/10/24, NA-E on 10/12/24, N A-L on 10/13/24, NA-F on 10/13/24, NA-G on 10/15/24, registered nurse (RN)-C on 10/15/24, NA-H on 10/18/24, NA-I on 10/23/24, NA-J on 11/2/24 and NA-K on 11/14/24.</p> <p>An undated facility COVID Testing Roster, identified staff name, test #1 results/date, test #2 results/date, test #3 results/date and symptoms. However, the roster failed to identify which staff were required to test or when. Review of the staff schedule 9/27/24 through 11/25/24, identified two registered nurses (RN), one trained medication aide (TMA), and 17 nursing assistants (NA) did not test according to CDC guidance during the breakout period. Additionally, one RN and 4 NAs were not listed on the COVID Testing Roster.</p> <p>During an interview with RN-D and the DON on 11/21/24 at 2:47 p.m., RN-D stated, if a staff member tested positive for COVID-19, RN-D sent an electronic communication to all staff working on the unit where the positive staff member last worked to notify them, they needed to test that day. RN-A spoke with dietary and activities staff, so they knew to test as well. RN-A then put a COVID-19 Testing Roster including all staff out on the unit. Staff were tested by the nurse working on the unit and marked off on the roster. However, RN-D did not identify any staff on the roster who were required to test. Review of the COVID-19 Testing Roster with the staff schedule, identified staff that did not test according to CDC guidance. The DON stated she believed the untested staff were casual staff that did not regularly work at the facility. Many tested while at home and called results into the facility, but there was no documentation of the result. RN-D stated the casual staff just didn't come into the facility to test. Additionally, the DON stated she believed the registered nurses also tested but forgot to document their results. The DON stated staff and residents were sick of COVID-19 and testing nonchalantly because they were not taking COVID-19 as seriously. It was frustrating. The facility needed to create a better tracking system to track staff and resident testing. Staff were expected to test before their shift and the facility needed to implement a system to do that. Additionally, the DON stated she needed to be informed of staff who refused to test so the DON can address it with the staff member. It was a system failure.</p> <p>RESIDENT TESTING</p> <p>A facility untitled spreadsheet dated 9/27/24 through 11/5/24, identified resident name, positive test date, symptom onset date, isolation period, out of isolation date, symptoms, and treatment (if any). The spread sheet identified 14 resident names with positive test results: R44 on 9/27/24, R39 on 9/30/24, R16 on 9/30/24, R42 on 10/2/24, R31 on 10/13/24, R4 on 10/13/24, R40 on 10/13/24, R1 on 10/13/24, R6 on 10/15/24, R33 on 10/15/24, R14 on 10/18/24, R26 on 10/21/24, R19 on 11/4/24 and R36 on 11/5/24.</p> <p>A facility COVID Testing Roster for residents was requested but not received.</p> <p>A facility list of residents tested due to symptoms was requested but not received.</p> <p>R36's quarterly Minimum Data Set (MDS) dated [DATE], identified R36 was [AGE] years old and had diagnoses that included hypertension.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R36's nursing progress note dated 11/5/24 at 12:54 p.m., identified R36 was seen during rounds this morning by the nurse practitioner (NP). Discussed R36's complaints regarding moods, pain, and general complaints of not feeling well. The NP discussed with R36 and R36 was agreeable to increasing dosage of Abilify (an antipsychotic medication). Received order via fax to increase dose from 2 milligram (mg) per day to 3 mg per day for 2 weeks and then, if tolerating, increase to 4 mg daily at HS for mood stability. Order entered. However, the note failed to identify what R36's complaints of not feeling well were and/or if R36 was tested for COVID-19.</p> <p>R36's nursing progress note dated 11/5/24 at 8:53 p.m., identified R36 tested positive for COVID-19. R36 was increasingly confused and restless, R36 was walking in hallway to get something to drink. R36 was assisted into bed and 15-minute checks were initiated.</p> <p>During an interview on 11/21/24 at 9:02 a.m., TMA-A stated symptoms of COVID-19 included sore throat, runny nose, congestion, all the symptoms a cold has and fevers. Whenever a resident showed symptoms like that, they should be tested because often it's COVID-19. Usually, the nurse on the unit collected the test and, if negative, the resident was tested again in two days. If symptoms resolved and the original test was negative, the second test did not need to be collected. When the facility was in a COVID-19 outbreak, staff needed to test every other day to make sure COVID-19 did not spread throughout staff, residents, and visitors.</p> <p>During an interview on 11/21/24 at 9:19 a.m., NA-W stated symptoms of COVID-19 included sore throat, cough, body aches, fever and then sometimes not a fever. Everyone was different, especially the elderly. During the facility's COVID-19 outbreak, NA-W stated she noticed many residents became incontinent of bowel and that was the first sign something was wrong. R36 had a cough, fever and just really bad body aches.</p> <p>During an interview on 11/21/24 at 9:38 a.m., RN-A stated R36 was tested for COVID-19 on 11/4/24 due to facility outbreak testing and was negative. On 11/5/24, R36 complained of body aches and headache. That was kind of R36's initial complaints and later also complained of a sore throat. RN-A stated she did not test R36 for COVID-19 when R36 complained of symptoms nor placed R36 into isolation because RN-A was focused on R36's pain. RN-A stated she was unsure when a resident should be placed into isolation for exhibiting symptoms because RN-A relied on RN-D to tell her.</p> <p>During an interview on 11/21/24 at 9:58 a.m., RN-D stated she was told R36 was tested for COVID-19 due to exhibiting symptoms but was unaware R36 had complained of COVID-19 earlier in the day nor had reviewed R36's chart.</p> <p>During an interview on 11/20/24 at 6:55 p.m., RN-D stated an COVID-19 outbreak was one or more positive case. The facility's first outbreak started on 9/27/24 and ended 10/21/24. Then the facility had another COVID-19 outbreak that started 11/4/24 and ended 11/15/24. An outbreak ended when residents and staff made it passed their isolation period and the facility had done 3 rounds of testing with no more positives on days 1, 3 and 5. The facility only needed to test 3 times and if no more positives, the outbreak was over. If there was another positive, the outbreak testing restarted until the facility had 3 consecutive tests without any further cases. RN-D did not keep any type of tracking of resident COVID-19 testing. The test was documented in the residents' electronic treatment administration record (ETAR). If a resident was positive, a nursing note would be documented as well.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- On 9/27/24, R44 tested positive for COVID-19 at 10:30 a.m. RN-D stated that was day 1 and all residents and staff who had not had COVID-19 in the past 30 days on that unit were tested that day, then residents were tested again three days later.</p> <p>- On 9/30/24, two residents tested positive on another unit and this threw off the facility's testing plan. The facility added an extra two days of testing to ensure COVID-19 was not spreading more. COVID-19 outbreak testing was halted on 10/4/24.</p> <p>- On 10/10/24, NA-D worked a partial shift in two units. The first unit, NA-D wore a mask because there were positive cases but when she moved to the other unit removed her mask. RN-D stated she was unaware NA-D was working in two units because the facility did not typically do that. On 10/10/24, RN-D implemented masking on all units, however, outbreak testing did not begin until 10/13/24. RN-D stated she should have kept a paper record of all resident and staff testing to ensure she was able to track testing. Tracking of testing would ensure all staff and residents were tested according to CDC guidance. R36's medical record failed to identify when R36 was placed into transmission-based precautions.</p> <p>During an interview on 11/21/24 at 3:08 p.m., the DON stated the residents were tested on days one, three and five and stopped testing positive on 10/4/24. The facility halted COVID-19 outbreak testing. Any new resident testing positive would have restarted the cycle of every two-day testing.</p> <p>The COVID-19 Confirmed Case Checklist updated 8/31/23, identified when a case of COVID-19 had been suspected/confirmed in the location:</p> <p>Isolate (suspected or confirmed case):</p> <p>The DON and Infection Preventionist determine isolation period:</p> <p>- The day of the positive test or symptom onset (whichever is sooner) is day zero.</p> <p>- Asymptomatic or mild to moderate illness: Isolate Day 0 through day 1 O</p> <p>- Severe to critical illness or residents with immunocompromising conditions: isolate up to 20 days. Test-based strategy may be used starting on Day 10, 2 negative tests 48 hours apart are needed to discontinue prior to day 20.</p> <p>- Confine resident to their room. Door should remain shut if safe. Pull privacy curtain. Isolate in a private room, if possible.</p> <p>- Initiate Airborne and contact transmission-based precautions.</p> <p>- Station with PPE including N95 respirator, eye protection, gowns and gloves available immediately outside of resident room.</p> <p>- Assign employees to care for the positive resident.</p> <p>- Implement source control masking in common spaces on affected units.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> - Look back two days from start of symptoms or positive test, whichever was sooner, to identify all residents, staff and visitors as able who had close contact or higher risk exposure with this resident. - Initiate outbreak testing via contact tracing or broad-based testing - Test all Employees and Residents determined to be close contacts/higher risk exposures on Day 1, Day 3, and Day 5 following the exposure. - Contact trace any additional identified positives. - If unable to conduct contact tracing, move to broad based testing of all employees and residents on a unit/hall or facility on Day 1, Day 3, and Day 5 - If the outbreak becomes uncontained, move to testing of all employees and residents every 3-7 days until no new cases of COVI D-19 are identified for 14 days. <p>Choosing a test</p> <ul style="list-style-type: none"> - Either Antigen or NAAT can be used. Antigen testing is preferred for symptomatic people and for people who have recovered from COVID-19 infection in the prior 31-90 days. - People should not be included in outbreak testing through contact tracing or broad-based testing for 30 days following the onset of their COVID-19 illness unless new symptoms develop, in which case antigen test should be used. - Instruct symptomatic employees to get tested immediately, prior to working. - Instruct positive employees to stay home. <p>Surveillance and Mitigation Plan for SNFs updated 4/26/23, identified if symptomatic residents test negative with an antigen test, they should be placed into transmission-based precautions, and in a single room, if possible, but not cohorted with a known positive resident until a confirmation test with a PCR is received or confirmation with another negative antigen test 48 hours later.</p> <p>41575</p> <p>EBP:</p> <p>R205's admission MDS dated [DATE], identified R205 had moderate impaired cognition. R205 had one stage three pressure ulcer and one unstageable ulcer present on admission. In addition, the MDS identified R205 had infection of foot and required pressure ulcer care and application of dressings to his feet. Diagnoses included dementia, anxiety, and diabetes.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R205's care plan dated 11/20/24, identified R205 had an unstageable pressure ulcer to his left second toe and stage three pressure injury to his right great toe. Staff were directed to monitor location, size and treatment of skin injury and report abnormalities to the provider, provide supplemental protein, vitamins, and minerals to support healing and notify nurse of any new skin breakdown or concerns.</p> <p>During observation on 11/20/24 9:55 a.m. licensed practical nurse (LPN)-A entered R205's room to change the dressing on his foot after applying alcohol-based hand sanitizer (ABHR). LPN-A gathered dressing supplies from R205's closet and put on gloves. LPN-A removed R205's sock on right foot. No dressings were visible and the wound on right great toe was left open to air. The wound was approximately three centimeters in diameter and was a stage two wound with a crater like appearance. LPN-A dabbed the wound with a 4x4 sponge. LPN-A changed gloves and applied iodisorb ointment with a cotton tipped swab into the wound bed. LPN-A covered the wound with a Band-Aid and put a sock and soft tennis shoe slipper onto R205's foot. LPN-A removed her gloves, put away supplies and washed her hands before exiting the room. There was no signage or personal protective equipment (PPE) cart outside of R205's room to indicate he was on enhanced barrier precautions.</p> <p>During interview on 11/20/24, at 1:45 p.m. LPN-A stated the infection preventionist (IP) determined and setup enhanced barrier precautions (EBP) when it was needed for residents. Staff identified when they needed to implement enhanced barrier precautions to care for a resident when a PPE cart and signage was located outside a resident's door. R205 has never needed EBP since his admission and so she just used gloves for the dressing change to his foot. LPN-A knew EBP were needed for resident with catheters or wounds but not exactly sure when they were required. LPN-A just relied on the IP nurse to let staff know when EBP was needed to care for residents.</p> <p>When interviewed on 11/21/24, at 11:15 a.m. registered nurse (RN)-C stated she did not know why R205 was not on EBP. The IP nurse had told staff it was not needed because R205's wounds were not significant enough to need precautions. The IP nurse reviewed resident conditions even before they were admitted and determined what type, if any, precautions were needed for their care. The staff followed what they were told by the IP nurse.</p> <p>When interviewed on 11/21/24, at 11:50 a.m. the IP nurse stated R205 had a chronic wound and EBP was not required when the wound was chronic in nature. R205 was admitted with the wounds on his feet. The wounds were rapidly healing and R205 did not have a history of skin conditions, so she did not feel EBP was needed.</p> <p>During observation on 11/25/24, at 10:45 a.m. a PPE cart and EBP signage was noted posted outside of R205's room, with instruction for staff to wear gown and gloves with any care or prolonged contact with R205.</p> <p>A facility policy on enhanced barrier precautions was requested, however none were received.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Centers for Disease Control and Prevention (CDC) Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 6/28/24, indicated wound care was included as a high-contact resident care activity and was generally defined as the care of any skin opening requiring a dressing. This generally included residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, and chronic venous stasis ulcers.</p> <p>Mask Use:</p> <p>R206's admission MDS dated [DATE], identified R206 had intact cognition. R206 was admitted with diabetic foot ulcer, open lesions on foot and application of dressings to feet. The MDS indicated antibiotics were administered daily.</p> <p>R206's care plan dated 11/25/24, identified R206 was on antibiotics for osteomyelitis with a peripherally inserted central catheter (PICC) in left arm. Antibiotics were ordered twice a day for six weeks. Staff were directed to monitor intravenous (IV) site in left arm every shift for symptoms of infection. The care plan also identified R206 was to be on enhanced barrier precautions due to her wounds and the presence of the PICC line. Staff were directed to don gown and gloves when performing high contact activities such as dressing, grooming, repositioning, wound care, and device care and use. The PICC dressing was to be changed weekly.</p> <p>During observation on 11/19/24, at 2:55 p.m. RN-C and RN-E entered R206's room after applying alcohol-based hand sanitizer (ABHR) and gloving and gowning. RN-E, with clean gloves and gown on, proceeded to carefully remove the transparent adhesive dressing covering the PICC line insertion site. RN-E was not wearing a mask during the procedure. RN-E removed her gloves and washed her hands. RN-E opened the PICC line sterile dressing change packet, setup a sterile field barrier sheet and put on the sterile gloves. RN-E put on a sterile mask and began cleaning the PICC line insertion site with the enclosed chlorhexadine swab. RN-C put on a pair of sterile gloves to assist RN-E. RN-C took the sterile paper measuring tape and measured R206's upper arm, leaning over the PICC line insertion site to do so. RN-C then applied the sterile transparent adhesive dressing to cover the PICC line insertion site. Both nurses disposed of used supplies removed gloves and washed hands and exited room.</p> <p>During interview on 11/19/24, at 3:15 p.m. RN-C stated she was not wearing a face mask when assisting RN-E with the PICC line dressing change and she should have been.</p> <p>When interviewed on 11/21/24, at 8:40 a.m. RN-E stated she had never received training on PICC line dressing changes from the facility, except for the mentoring that was observed on 11/19/24, while doing the procedure. RN-E verified she was not wearing a mask when removing the dressing covering the PICC line insertion site. RN-E stated she should have been wearing a face mask during the procedure.</p> <p>During on 11/21/24, at 11:55 p.m. the director of nursing (DON) stated it was the facility's expectation to perform PICC line dressing changes using sterile technique and procedures.</p> <p>The facility policy Peripherally Inserted Central Catheter dated 4/1/24, directed staff to perform hand hygiene and put on a face mask when performing a PICC line dressing change.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943</p> <p>Based on interview and document review the facility failed to establish a process for antibiotic review in order to determine appropriate indications for use of an antibiotic for 1 of 1 resident (R15) reviewed for antibiotic use.</p> <p>Findings include:</p> <p>R15's quarterly Minimum Data Set (MDS) dated [DATE], identified R15 had diagnoses that included renal insufficiency, diabetes, Alzheimer's disease, and dementia. R15 was always continent of bowel and bladder and required supervision or touching assistance with personal hygiene.</p> <p>The Monthly Report of Resident Infections in Location dated November 2024, identified R15 had a urinary tract infection with an onset date of 11/2/24. Symptoms included gross hematuria and flank pain related to kidney stones. However, the report failed to identify if R15 was treated with an antibiotic and/or if a urinalysis or urine culture were obtained.</p> <p>R15's Order Summary Report dated 11/2/24, identified R15's was prescribed cefdinir (an antibiotic) 300 mg capsules give 1 capsule by mouth two times a day for acute cystitis with hematuria for 10 days.</p> <p>R15's nursing progress note dated 11/2/24 at 8:58 a.m., identified R15 was transferred to the emergency department (ED) due to abdominal pain.</p> <p>- At 2:15 p.m., R15 returned from the ED with new orders for cefdinir 300 mg two times a day for 10 days. R15 had acute cystitis with hematuria (a conditions where a person develops cystitis (inflammation of the bladder) with the presence of blood in the urine) and ureterolithiasis (kidney stones).</p> <p>R15's urine culture dated 11/24/24, identified mixed microflora (mixed microflora in urine culture typically indicates the culture yielded two or three different organisms, which may be considered colonization rather than infection.)</p> <p>During an interview with registered nurse (RN)-D on 11/19/24 at 1:35 p.m., RN-D stated she was responsible for the infection control program in the facility and tracked all antibiotic use. R15 was evaluated in the ED for kidney stones. R15 returned from the ED with an order for cefdinir to treat a UTI even though that wasn't a typical treatment for kidney stones. R15's urine culture identified mixed microflora and the culture was reviewed by the ED medical provider and determined it was a contaminated urine sample. However, by the time the culture returned, the antibiotic treatment was almost completed.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- At 1:42 p.m., RN-D stated the facility used McGreer Criteria to determine if an antibiotic was warranted. However, RN-D stated McGreer Criteria was a steep level and residents had horrible infections by the time they reached the point of meeting criteria. The facility did review antibiotic orders during the morning meetings Monday through Friday, but RN-D stated she could not speak to what the nursing staff did at the unit level. RN-D stated the primary rounding providers were very involved in antibiotic stewardship and conducted 48-hour timeouts (an antibiotic timeout prompts a reassessment of the continuing need and choice of antibiotic when the clinical picture is clearer and more diagnostic information is available) on all UTI and generally did not order antibiotic treatment unless necessary. However, the ED providers ordered antibiotics for everything. The ED had a huge rotating schedule of providers and that was why the facility received orders for kidney stones, chronic obstructive pulmonary disease (COPD) exacerbation and other illnesses not normally treated with antibiotics. RN-D had spoken with the medical director regarding concerns with orders prescribed by ED providers, but the topic had not gone past talking about it. RN-D stated she did not know who she would talk to at the hospital about antibiotic stewardship concerns and had not attempted.</p> <p>During an interview on 11/25/24 at 3:46 p.m., the director of nursing (DON) stated antibiotic stewardship was reviewed with each case because each case was different. When a resident returned from the ED with an order for an antibiotic, the provider was frequently no longer at the facility to review lab results with by the time the facility received results. The ED providers worked 7 days on and 7 days off and it was just difficult to speak with them. The DON stated she could not speak to any discussion that had been had with the hospital regarding antibiotic stewardship concerns or who to reach out to for concerns with lab results, but guessed the hospital would direct staff to reach out to the primary provider. The staff should be following McGreer Criteria to determine antibiotic treatment was appropriate and, for contaminated urine samples, another sample should have been collected with the intention to stop the antibiotic treatment. When R15 returned from the ED, there should have been follow up to determine if the antibiotic should have been stopped.</p> <p>The facility policy Definitions of Infection - For Surveillance Purposes Only, Infection Control, R/S LTC dated 11/1/23, identified the facility used McGreer Criteria for UTI:</p> <p>Resident without indwelling catheter:</p> <p>At least one of the following signs or symptoms from these sub-criteria:</p> <ul style="list-style-type: none"> - Acute dysuria or acute pain, swelling or tenderness of the testes, epididymis or prostrate. - Fever or leukocytosis and at least one of the following localizing urinary tract sub-criteria: - Acute costovertebral angle pain or tenderness - Supra-pubic pain - Gross hematuria - New or marked increase in incontinence. - New or marked increase in urgency. <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - New or marked increase in frequency. - In the absence of fever or leukocytosis, then two or more of the following localizing urinary tract sub-criteria must be present: <ul style="list-style-type: none"> - Supra-pubic pain - Gross hematuria - New or marked increase in incontinence. - New or marked increase in urgency. - New or marked increase in frequency. And One of the following: <ul style="list-style-type: none"> - At least 105 colony-forming units (cfu)/milliliter (ml) of no more than two species of microorganisms in a voided urine sample - At least 10² cfu/ml of any number of organisms in a specimen collected by an in-and-out catheter. <p>Comments: UTIs should be diagnosed when there are localizing genitourinary signs and symptoms and a positive urine culture result. A diagnosis of UTI can be made without localizing symptoms if a blood culture isolate is the same as the organism isolated from the urine and there is no alternate site of infection. In the absence of a clear alternate source of infection, fever, or rigors with a positive urine culture result in the non-catheterized resident or acute confusion in the catheterized resident will often be treated as a UTI. However, evidence suggests that most of these episodes are likely not due to infection of a urinary source.</p> <p>Urine specimens for culture should be processed as soon as possible, preferably within one or two hours. If urine specimens cannot be processed within 30 minutes of collection, they should be refrigerated. Refrigerated specimens should be cultured within 24 hours.</p>		