STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - International Falls	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure shaving preferences were assessed and provided for 1 of 5 residents (R8) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care.Findings include:R8's annual Minimum Data Set MDS dated [DATE], identified R8 had severe cognitive impairment and diagnoses that included dementia. R8 required substantial/maximal assistance for personal hygiene.R8's medical record lacked evidence his shaving preferences were assessed.R8's care plan revised 12/2/25, identified R8 had an ADL self-care performance deficit related to right shoulder pain, dementia, and a traumatic brain injury exhibited by need for assist with ADL's. The care plan directed staff R8 required assist of one staff to complete personal hygiene. However, the care plan failed to address R8's shaving preferences.During an observation on 1/13/26 at 8:58 a.m., R8 was up, dressed for the day and sitting in his wheelchair at a table in the dining room. R8 had an approximately 1/4 inch beard growth. During an observation on 1/13/26 at 9:28 a.m., nursing assistant (NA)-A and NA-B assisted R8 to toilet and lie down in bed. NA-A nor NA-B offered R8 shaving.During an observation on 1/13/26 at 2:10 p.m., R8 was lying in bed and was covered with blankets to his chest. R8 continued to have an approximately 1/4 inch beard growth. During an interview on 1/13/26 at 2:21 p.m., NA-A stated residents were only shaved on their bath days due to staffing and it's just too hectic down here.During an interview on 1/13/26 at 5:01 p.m., licensed practical nurse (LPN)-A stated residents were shaved on their bath days or if the resident requested to do it. If a resident was unable to request, shaving would only occur on their bath days. During an interview on 1/13/26 at 5:10 p.m., family member (FM)-A stated R8 always shaved every day, and she tried to have to staff shave R8 at least every other day. I don't like it, but I have a hard time to get anyone to do it.During an interview on 1/14/26 at 10:15 a.m., registered nurse (RN)-A stated staff were not expected to shave male residents every day, but it depended on the resident's preference. RN-A stated she was unaware of any resident that wanted to be clean shaven every day and shaving usually happened on shower days. If family wanted a resident shaved more often, staff should be doing that and directed in the resident's care plan. The facility policy Activities of Daily Living revised 12/1025, identified Any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. Based on the resident's comprehensive assessment, the center will ensure the resident's ability in activities of daily living (ADL) does not decline except when unavoidable for reasons of disease progression, deterioration of physical condition associated with disability or refusal of care/treatment by the resident or legal representative. Evidence of any of these reasons will be reflected in the medical record. ADLs are those necessary tasks conducted in the normal course of a resident's daily life. Included in these are the following: general personal, daily hygiene/grooming: care of hair, hands, face, shaving, applying makeup, skin, nails and oral care.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to promptly notify the ordering primary care provider of an abnormal laboratory result for 1 of 5 residents (R4) reviewed for unnecessary medications.Findings include: R4's significant change Minimum Data Set (MDS) dated [DATE], identified R4 was cognitively intact and required maximal assistance with dressing and moderate assistance with toileting, grooming and transfers. Diagnoses included atrial fibrillation (irregular heartbeat), anemia, depression, long term use of anticoagulants and dysphagia (difficulty swallowing). P4's Elder Care 60 Day Regulatory Visit dated 11/17/25, identified P4 was being seen for regular routine rounds with orders to draw yearly comprehensive blood count with differential (CBC), basic metabolic panel (BMP), thyroid stimulating hormone (TSH). prothrombin time (PTT) and a ferritin level (which indicated the amount of iron stored in the body). P4's medical record lacked documentation of lab work drawn, or results of any blood tests. P4's physician medication orders identified P4 received ferrous sulfate (an iron supplement) 325 milligrams every morning for anemia. During interview on 1/13/26, at 11:31 a.m. registered nurse (RN)-B stated there was an order to draw lab work for P4 in November. The medical center's laboratory staff came weekly to draw resident's labs. RN-B obtained the laboratory results in the residents shared one chart and printed them. If lab work was normal, she put it in the facility scanning pile to be scanned by activity staff. If there were abnormal laboratory results RN-B would call the resident's primary care provider and document that in the resident's progress notes. RN-B was unable to locate P4's laboratory results from lab work in November or documentation of lab work in P4's progress notes. RN-B was able to locate the ordered laboratory results in P4's shared one chart and printed the results to be scanned into P4's medical record. P4's laboratory results completed on 11/18/25, identified a blood sample was obtained to complete a CBC, BMP, PTT, TSH and ferritin level. An abnormal ferritin level was identified with a high value of 574-unit nanograms per milliliter (ng/ml) with normal reference range of 5 to 204 ng/ml. R4's progress notes 11/18/25 to 1/13/26 and rounding provider visit notes on 11/25/25 and 12/17/25, lacked documentation of review of lab results obtained on 11/18/25, or provider notification of the abnormal ferritin level. During interview on 1/13/26, at 11:53 a.m. RN-A stated it was not the facility's practice to document labs drawn or lab results into the resident charts. The nurse managers printed off the lab results from the resident's shared one chart and put them in to be scanned into the resident's facility chart after reviewing the results. It would be difficult to determine if the lab results had been reviewed or if the primary care provider had been notified of abnormal results. Sometimes RN-A called the provider, or the provider called the facility to address abnormal labs. RN-A was unable to find provider documentation of the lab results from lab work obtained 11/18/25 and stated it would be important to know the provider was aware of any abnormal lab work and she was unable to find documentation R4's lab elevated ferritin level had been reviewed by the provider. During interview on 1/14/26, at 10:44 a.m. the director of nursing (DON) stated the facility's practice was to have nurse managers go into the resident's shared one chart and obtain lab results as the results rarely got sent to them automatically. If lab work had abnormal results, the nurse manager should let the provider know. The nurse managers should be documenting the lab results in the resident's medical record, and the DON did not feel that was currently being done. For P4's elevated ferritin level, the facility should have called the provider to ensure the abnormal level was addressed. The facility's policy Laboratory Services dated 12/1/25, identified laboratory services would be done only when ordered by a physician, physician assistant, nurse practitioner or clinical nurse specialist. Findings would be reported to the medical provider who ordered the test in a timely fashion. Laboratory results would be noted by a licensed nurse and scanned int the resident's medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was provided following personal cares for 2 of 5 residents (R5, R8) observed during the provision of activities of daily living (ADLs).Findings include:R8's annual Minimum Data Set (MDS) dated [DATE], identified R8 had severe cognitive impairment with a diagnosis of dementia. R8 required substantial/maximal assistance for personal hygiene.R8's care plan revised 12/2/25, identified R8 had an ADL self-care performance deficit related to right shoulder pain, dementia, and traumatic brain injury exhibited by the need for assist with ADL's. R8 required assist of one staff for personal hygiene. R8 required stand aide with assist of 1 and a riser on the toilet for toileting. R5's quarterly (MDS) dated [DATE], identified R5 was cognitively aware and had diagnoses that included hemiplegia and hemiparesis (left sided weakness). R5 required substantial/maximal assistance with toileting.R5's care plan revised 7/27/25, identified R5 had an ADL self-care performance deficit related to previous cerebral vascular accident (CVA) (stroke) with left sided hemiplegia/hemiparesis, osteoarthritis, contractures to left wrist and left foot, pain and weakness. R5 was usually continent of bowel and bladder, with occasional urge incontinence. R5 worse a pull-up incontinent brief. R5 will inform staff of need to toilet, requires staff assistance of 1 with sit to stand mechanical lift. Staff provide peri hygiene and assist with pants.During an observation on 1/13/26 at 9:28 a.m., NA-A and NA-B put on gowns, gloves and surgical masks upon entering the room. NA-A nor NA-B used hand sanitizer prior to putting on their gloves. NA-A drained R8's catheter bag.At 9:38 a.m., NA-A and NA-B to stand using a mechanical lift. NA-A pulled down R8's pants and incontinent brief and stated R8 had a small bowel movement. R8 was wheeled to the toilet and, while standing in front of the toilet in the mechanical lift, NA-A cleaned the feces from R8's skin.At 9:40 a.m., NA-A cleaned R8's catheter tubing with a disposable wipe.At 9:42 a.m., R8 sat down on the toilet because he started to have a bowel movement. NA-B gave R8's his call light. NA-A continued to wear the same gloves. At 9:44 a.m., NA-B removed their gloves and gown and did not perform hand hygiene and left R8's room.At 9:48 a.m., NA-B returned to R8's room and put on a gown and gloves. R8 was raised off the toilet and NA-A cleaned the feces from R8's skin with a disposable wipe.At 9:55 a.m., R8 was assisted to lie down in bed. NA-A and NA-B removed their gowns and gloves and exited R8's room. Neither washed their hands and/or used hand sanitizer. At 9:59 a.m., NA-A entered R5's room with the mechanical lift without washing her hands or using hand sanitizer. NA-A applied gloves and transferred R5 from her wheelchair to the toilet using the mechanical lift.At 10:03 a.m., NA-A was observed to assist R5 with cleaning her perineum with a disposable wipe, then pulled up R5's pants and assisted R5 to transfer back into her wheelchair.At 10:05 a.m., NA-A removed her gloves but did not wash her hands or use hand sanitizer before exiting R5's room. During an interview on 1/13/26 at 10:08 a.m., NA-A stated she should have washed her hands the second she took off her gloves after R8's perineal cares so I don't spread germs around the room. Also, NA-A stated she should have either washed her hands or used hand sanitizer before entering R5's room. During an interview on 1/14/26 at 10:15 a.m., registered nurse (RN)-A stated staff should have washed hands after doing bowel movement incontinence cares or any peri-care before moving on to clean areas. Additionally, staff were expected to either wash hands or used hand sanitizer before moving on to the next resident. The facility policy Hand Hygiene revised 11/13/25, identified the purpose of the policy was to establish hand hygiene as the single most important factor in preventing the spread of disease-causing organisms to patients and personnel in healthcare settings. All employees in patient care areas (unless otherwise noted in their policy will adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene.1. Entering Room2. Before Clean Task3. After Bodily Fluid/Glove Removal4. Exiting Room5. Zones: Patient zone and Health-care zones.