

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Albert Lea		STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240th Street Albert Lea, MN 56007	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>49616</p> <p>Based on interview and record review the facility failed to ensure routine weekly skin assessments for impaired skin integrity for 2 of 3 residents (R1, R2) who had impaired skin integrity.</p> <p>Findings include:</p> <p>R1's Minimum Data Set (MDS) quarterly review dated 6/12/24, identified R1 had severe cognitive impairment. Diagnoses included cancer, and an open lesion with application of non-surgical dressings.</p> <p>R1's care plan revised on 3/21/23, indicated R1 had a potential impairment to skin integrity with a non-healing lesion on the top of his head. Interventions included to monitor location, size and treatment of skin injury, report abnormalities including failure to heal, signs/symptoms of infection, maceration, etc. to health care provider. Avoid scratching and keep hands and body parts from excessive moisture.</p> <p>R1's Wound Data Collection identified on 5/4/24, an initial data collection for the growth on top of R1's head. The assessment did not include wound measurements and a description of the wound.</p> <p>Review of R1's record did not include weekly comprehensive wound assessments for the growth on R1's head; the record included the following measurements recorded as length by (x) width x depth:</p> <p>5/18/24- 4.5 centimeters (CM) x 5.5 cm x 2.5 cm</p> <p>5/23/24- 5.5 cm x 6.0 cm x 2.5 cm</p> <p>5/30/24- 5.0 cm x 1.5 cm x 5.0 cm</p> <p>6/5/24- 5.5 cm x 5.5 cm no depth measured</p> <p>6/19/24- 7.5 cm x 6.0 cm x 2.5 cm</p> <p>6/30/24- 6.0 cm x 8.0 cm x 2.5 cm</p> <p>Missed weekly measurements included 5/11/24, 6/1/24, 6/12/24, 6/30/24, and 7/7/24.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's face sheet dated 7/10/24, identified diagnoses included hemiplegia and hemiparesis, gout, anxiety disorder, and bilateral primary osteoarthritis.</p> <p>R2's care plan revision dated 7/9/24, identified suspected deep tissue injury (SDTI) to the right great toe on 6/8/24, stage 3 pressure ulcer on back of left lower leg on 7/8/24. Interventions included to reposition in bed and chair every two hours and as needed, make sure heels are floated at all times with pillows, keep covers off of feet with use of foot cradle at end of bed. Assess/record/monitor wound healing daily with wound data collection user defined assessment (UDA), and weekly wound UDA. Report improvements and declines to the health care provider.</p> <p>R2's UDA wound data collection dated 6/8/24, identified an initial wound data collection for the SDTI of right great toe. No measurements or wound description provided with assessment. The Wound Data Collection had been completed daily from 6/8/24-7/10/24 but did not include consistent descriptions of the wound or measurements.</p> <p>R2's SDTI right great toe wound was measured:</p> <p>-6/20/24- 1.9 cm x 1.3 cm</p> <p>-6/28/24- 1.4 cm x 0.8 cm</p> <p>R2's did not include wound assessments for 6/15/24 and 7/5/24.</p> <p>During an interview on 7/10/24 at 10:59 a.m., registered nurse (RN)-B stated all wounds including pressure, skin tears, and surgical incisions were supposed to be assessed every every Wednesday and Sunday.</p> <p>During an interview on 7/10/24 at 11:37 a.m., clinical manager (CM)-A indicated she was the person responsible for wound tracking. CM-A explained wound measurements had not been followed up on in awhile because she had been gone for most of June. CM-A reviewed wound measurements and acknowledged missing measurements for R1.</p> <p>During an interview on 7/10/24 at 2:57 p.m., Administrator, assistant director of nursing (ADON), and infection preventionist (IP) were present. IP stated wounds should be measured at least weekly.</p> <p>The Pressure Ulcer/Wound Care Resource Packet-rehab/skilled revised 6/5/24, identified wound care management may include the management and treatment of surgical wounds, pressure ulcers, diabetic ulcers and skin conditions, as well as arterial and venous ulcers.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>49616</p> <p>Based on observations, interviews, and document review the facility failed to maintain accurate medical records for 1 of 3 residents (R1) reviewed related to wound management.</p> <p>Findings include:</p> <p>R1's Minimum Data Set (MDS) quarterly review dated 6/12/24, identified R1 had severe cognitive impairment. Diagnoses included cancer, and an open lesion with application of non-surgical dressings.</p> <p>R1's care plan revised on 3/21/23, identified a potential impairment to skin integrity with a non-healing lesion on the top of his head. Interventions included to monitor location, size and treatment of skin injury, report abnormalities including failure to heal, signs/symptoms of infection, maceration, etc. to health care provider.</p> <p>Review of R1's progress notes included a change in skin condition that was identified on 7/8/24 however was not documented until 7/10/24.</p> <p>R1's progress note with a created date of 7/10/24 at 10:04 a.m. and documented effective date of 7/8/24, identified R1's family member had been notified of maggots in the wound on top of R1's head and what staff were doing for it. The note did not include the time R1's family was notified.</p> <p>R1's progress note with a created date of 7/10/24 at 11:09 a.m., and documented effective date of 7/8/24, identified R1 had maggots in the lesion on his head. Nurse practitioner was aware and had staff irrigate the lesion. Nurse practitioner saw the maggots.</p> <p>No further information pertaining to the extent of maggot infestation of wound and subsequent monitoring was evident.</p> <p>During an interview on 7/10/24 at 11:17 a.m., nursing assistant (NA)-A stated R1 would take the dressing off at night. NA-A noted R1's dressing was on when she got him up on 7/8/24 around 9:45 a.m. and the nurse changed the dressing and found the maggots.</p> <p>During an interview on 7/10/24 at 10:04 a.m., Registered nurse (RN)-A stated she thought sometime during the night on 7/8/24 R1 had pulled off the scab that had been on the top of his head. RN-A had clinical manager (CM)-A examine the wound and CM-A found maggots in the wound. RN-A stated on 7/8/24 the maggots were very tiny, she rinsed the top of R1's head with vinegar in the shower and applied xeroform and an ABD (absorbent dressing). On 7/9/24, the maggots had become large enough to pick off with a tweezers and on 7/10/24 the maggots were gone.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/10/24 at 11:37 a.m., CM-A stated on 7/8/24 while observing the dressing change she saw little things moving in the wound. CM-A stated R1 had always pulled the dressings off and staff were not able to keep any dressings on very well. CM-A stated the nurse practitioner (NP) had them try xeroform with an ABD pad over the wound without an order for the first day to see if R1 would keep it on. The NP came back the next day and gave an order for the dressing. CM-A stated on 7/9/24, there were a few maggots and they moved very fast so they used a tweezers to get them before the maggots could get into the wound crevices. CM-A stated she had not documented any of the treatments or findings. CM-A reviewed R1's record and indicated no documentation had been completed on the wound or the presence of maggots. CM-A added late entry notes in to the chart about notifying family and the nurse practitioner.</p> <p>During an interview on 7/10/24 at 2:57 p.m., Administrator, assistant director of nursing (ADON), and infection preventionist (IP) the ADON stated it was very important to have timely documentation. ADON stated there were times when documentation was not completed timely and a late entry should be added in the medical record so staff could know what was happening with a resident.</p> <p>The Nursing Documentation Guidelines, Timeliness-rehab/skilled revised on 5/6/24, identified the purpose to systematically and continuously collect information about the health status of the resident and to ensure appropriate documentation is completed in a timely manner.</p> <p>Incidental charting-day-to-day type documentation of specific occurrences will be completed by a licensed nurse in the appropriate progress note determined by the content of the note.</p>		