STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Albert Lea	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355 Based on interview and record review the facility failed to provide safe transfers and follow the care plan to prevent accidents for 1 of 3 residents (R1) reviewed for falls. The facility's failure resulted in harm when R1 fell and sustained a left hip fracture that required surgical intervention. The facility implemented immediate corrective actions prior to survey and is issued at past non-compliance. Findings include: R1's quarterly Minimum Date Set (MDS) dated [DATE], indicated R1 did not have cognitive impairment. R1's diagnoses included legally blind and diabetes. R1 required one staff assist for staff transfers, toileting hygiene, upper and lower body dressing, and walking. R1 received anticoagulants (blood thinning medications). R1's fall care plan dated 12/1/23, indicated R1 was at risk for falls due to vision deficit. R1's activities of daily living (ADLs) care plan with the intervention dated 6/10/22, indicated R1 required one staff assist with gait belt for ambulation to and from the bathroom, meals, and activities. Review of video recording dated 8/24/24 at 6:58 a.m., revealed R1 entered his room from his bathroom with assist from nursing assistant (NA)-C and gait belt. NA-C was holding onto the back of the gait belt and R1's left lower forearm. NA-C moved around R1 and let go of gait belt and R1's wrist. NA-C then stepped away from R1 toward wheelchair. R1 lost his balance and fell backward landing on floor in front of doorway. R1 hit his head on bedside stand inside of door. Licensed practical nurse (LPN)-B opened the door and asked, what happened? NA-C replied R1 slipped. R1 stated he thought his hip was broken and was in pain. LPN-B and NA-C moved R1 further away from the doorway. R1 continued to express pain in his hip and thought it was broken. R1 refused to be transferred from the floor and LPN-B directed other staff to call for ambulance. R1's progress note dated 8/24/24 at 7:14 a.m., indicated R1 was transferred to the emergency department via ambulance due to fall. R1's progress note dated 8/24/24 at 9:30 p.m., call was placed to emergency department for update. R1 was transferred to higher level of care hospital for displaced left hip fracture. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 9/3/24 at 1:55 p.m., R1 returned to the facility following hospital surgical repair of fractured left hip. During an interview on 9/11/24 at 9:34 a.m., NA-C stated on 8/24/24, she was walking R1 to his wheelchair from bathroom with the gait belt on. NA-C let go of the gait belt to secure the wheelchair and R1 fell and broke his hip. NA-C stated she should not have let go of the gait belt. NA-C explained she was placed on leave and was re-educated on safe transfers and gait belt usage prior to returning to work. During an interview on 9/11/24 at 7:03 a.m., LPN-B stated she was working the morning R1 fell on [DATE]. LPN-B had been passing medications when she heard a bang and R1 yelling. When she entered the room, R1 was lying in front of the door. LPN-B was under the impression R1's care plan was followed at the time of the fall based on NA-C's report that R1 had slipped when he was being walked to the bathroom. LPN-B indicated NA-C should not have let go of the gait belt until R1 was safely seated. During an interview on 9/11/24 at 12:34 p.m., director of nursing (DON) stated when he first learned about the incident he was told R1 slipped and fell . DON thought the care plan was being followed until on 8/27/24, FM-A brought in a copy of the video. Administrator and DON watched the video with family present and were able to see NA-C had let go of the gait belt and R1 falling to the floor as a result of losing his balance. After viewing the video, the facility re-educated all staff on 8/27/24, on safe transfers and expectations for using the gait belt during transfers. Review of the facility's attestation statement Plan of Care/Gait Belt dated 8/2024 in conjunction with the facility staff nursing roster and Gait Belt Transfer/Ambulation Audits indicated all staff acknowledged they received and understood education on the use of gait belt and following the care plan of residents within the facility between 8/27/24 and 9/5/24. Staff are to check the Kardex/care plan prior to assisting residents with mobility, including transfers and/or ambulation. The Kardex/care plan includes use of gait belt for transfers/ambulation, staff are to hold on to the gait belt the entire time until the resident is safely seated on the destination surface. Review of facility policy titles Gait-Transfer Belt, dated 5/2/24, indicated gait belts were to be used with assisted ambulation unless medically contraindicated. A gait belt was never to be used as a lifting device, only for stabilization. -4. When holding the belt, an underhand grasp should be used. -6. Transfer or ambulate resident and remove belt.

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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** 42355 Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions ((EBPs), an infection control intervention designed to reduce the spread of infections which employs targeted gown and glove use during high contact resident care activities) were implemented for 2 of 2 residents (R4, R6) observed with implanted medical devices. Findings include: R4 R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R4 was dependent on staff with all activities of daily living (ADLs). R4's diagnoses included multiple sclerosis, ostomy (surgical opening for his bowels), and urinary catheter. R4's infection care plan dated 4/5/24, indicated R4 required EPBs related to supra pubic catheter (a tube that drains urine from the bladder through a small incision in the lower abdomen) and ostomy (a surgical opening for his bowels on abdomen). Interventions directed staff to don a gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking, and changing, device care and/or use, and wound care. During an observation on 9/10/24 at 4:56 p.m., nursing assistant (NA)-E assisted NA-M to get R4 out of bed. NA-M had on personal protective equipment (PPE) including gloves, gown, and a mask. NA-E did not have a gown or gloves on when she assisted NA-M with turning R4 over, pulling R4's pants up and placing the mechanical lift sling underneath him. Then NA-E assisted with transferring R4 out of bed to his wheelchair using the full body mechanical lift. During an interview on 9/10/24 at 5:05 p.m., NA-E stated she should have put on gown and gloves but did not think about it, even though NA-M had on gown, gloves, and mask. NA-E stated R4 was on EBP's and supplies were stored on his door. R6 R6's quarterly MDS dated [DATE], indicated R6 had an indwelling urinary catheter and a feeding tube (tubes mainly inserted into the gastrointestinal (GI) tract to provide a patient with a route for enteral nutrition). R6 required partial to substantial assistance from staff with his ADLs. R6's infection care plan dated 4/5/24, indicated R6 required EBPs related to indwelling catheter. Interventions directed Staff to don a gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking, and changing, device care and/or use, and wound care. R6's care plan failed to identify a need for EBP's with G-tube (gastrostomy tube, a type of feeding tube) care and the administration of medications via G-tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 9/11/24 at 10:10 a.m., licensed practical nurse (LPN)-D entered R6's room without putting a gown on and used hand sanitizer but did not put on gloves. LPN-D turned off R6's tube feeding pump and disconnected the tubing from R6's feeding port. LPN-D prepared R6's medications to administer via feeding tube then put gloves on prior to administering them. During an interview on 9/11/24 at 2:09 p.m., LPN-D stated she did not know she needed to wear a gown while administering medications via G-tube. LPN-D indicated she was not aware EBP's were necessary when administering medications through a feeding tube. During an interview with the director of nursing (DON) on 9/11/24 at 12:14 p.m., the DON stated it was his expectation that PPE be worn by all staff when indicated. DON reviewed the facility policy and confirmed the medications through the G-tube would require PPE to be worn as the contents of the g-tube or stomach could come back out of the G-tube and get on staff or resident. Review of facility policy titled Standard and Transmission-Based Precautions, dated 4/2/24 indicated the following: -Enhanced barrier precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high- contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. -Enhanced barrier Precautions are needed for residents with chronic wounds (Pressure Ulcers, Diabetic Foot Ulcers, Unhealed surgical wounds, and venous statis ulcers) and Residents with Indwelling Medical devices (central lines, hemodialysis catheters, indwelling urinary catheters, feeding tubes, and tracheotomies). -High-Contact Resident Care Activities include transfers, dressing, assisting during bathing, providing hygiene, changing briefs, or assisting with toileting, working with resident in therapy gym, specifically when anticipating close physician contact while assisting with transfers and mobility, changing linens, device care or use (central line, urinary catheter, feeding tube, tracheostomy), and wound care.