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	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Albert Lea	75507 240th Street Albert Lea, MN 56007

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on observation, interview, and record review the facility failed to ensure the call light was within reach of 1 of 1 resident (R49) reviewed for falls. R49's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated severely impaired cognition and diagnoses of chronic kidney disease (CKD), altered mental status, and a history of falling. It further indicated R49 was independent with most activities of daily living (ADL) and mobility. R49's Falls Risk Tool dated 3/13/25, indicated R49 scored a 20 which was considered a high risk for falls. R49's care plan dated 3/31/25, indicated R49 was at risk for falls related to requiring stand by assist with transfers and ambulation but frequently independently transferred/walked in her room. It further included the following interventions: -Educate resident/family about safety reminders and what to do if a fall occurs. -Educate resident/family/IDT as to causes of fall. -Remind resident to call/wait for staff assistance rather than self transferring. -Ensure the resident is wearing appropriate footwear with non slip soles such as gripper socks or shoes with non-skid soles. -Review as indicated for significant changes in cognition, safety awareness and decision-making capacity. -Review resident's history of recent or recurrent falls. -Review resident's medical record for medications or combinations of medications that could predispose to falls/increase fall risk. -Review status of any medical conditions that predispose to falls or that could increase the risk of injury from fall. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 4/21/25 at 12:29 p.m., R49 was sitting in her room in a recliner located at the back of the room by the window. Her call light box had been removed from the wall and was sitting on her bedside table next to the bed and was not within reach. During observation and interview on 4/21/25 at 12:39 p.m. registered nurse (RN)-A verified R49's call light was not within reach and this was important because if she would have fallen, she wouldn't have been able to call for help. During interview on 4/24/25 8:20 a.m., nursing assistant (NA)-A stated call lights should be placed right next to the residents when leaving the room. They should always be in place so the residents can let us know if they need something. During interview on 4/24/25 at 9:47 a.m., the director of nursing (DON) stated call lights should be kept within reach of the residents unless they prefer to keep it in a certain location in their room. The DON further stated there was no documentation that indicated the residents preferences. The facility's policy regarding call lights dated 7/29/24, indicated the purpose of the policy was to ensure residents always had a method of calling for assistance and to promptly answer the residents call light. It further indicated the procedure for answering call lights was as follows: 1. New admission- explain and demonstrate the use of call light system. 2. When a residents call light is observed/heard, go to residents room promptly. 3. Respond to the request as soon as possible. Turn the call light off and inquire about the residents request. 4. When leaving the room, place the call light within easy reach of resident. 5. For residents unable to use call light, care plan appropriate interventions and provide an adaptive call light if applicable. 6. Each facility is responsible for having an alternate method of communication during a loss of power or call light system failure.

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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** 42586 Based on observation, interview, and document review the facility failed to provide timely incontinence care for 1 of 2 residents (R23) reviewed for activities of daily living (ADL). R23's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated severely impaired cognition and diagnoses of dementia and epilepsy. It further indicated R23 had no rejection of care behaviors, required partial to moderate assistance with toileting, was frequently incontinent of bladder, and always incontinent of bowel. R23's Care Area Assessment (CAA) dated 3/13/25 triggered for urinary incontinence due to requiring staff assistance with incontinent personal hygiene. It further indicated R23 had functional incontinence. R23's care plan dated 3/31/25, indicated had bladder incontinence related to a traumatic brain injury (TBI) as evidenced by (E/B) functional incontinence with the following interventions: -avoid food/beverages that may irritate bladder i.e., fruit juices, spicy foods, tomato based products, carbonated drinks, artificial sweeteners, corn syrup, sugar, chocolate, coffee, tea, alcohol, etc. -R23 preferred to use his bathroom. -mattress protector on his bed -R23 used incontinence products (medium pull up). Check every shift and as needed (prn). It further included R23 was resistive to care r/t a diagnosis of noncompliance with medical treatments and regimen as e/b refusing assistance from staff at times, refusing showers, cares, change his clothes, and allowing staff to clean his room with the following interventions: -provide consistency in care to promote comfort with ADLs. -maintain consistency in timing of ADLs, caregivers and routine, as much as possible. -if R23 resists with ADLs, reassure him, leave and return 5-10 minutes later and try again. -negotiate a time for ADLs so that the resident participates in the decision making process and return at the agreed upon time. He prefers to set his own daily routine and direct his own cares. -educate resident/family of the possible outcome(s) of not complying with treatment or care. -resistive to care: encourage him to participate in cares and provide him with education on the safety risks and possible consequences of him not having cares completed. -calendar placed in resident's room with shower days and stickers on what days shower has been completed as a visual reminder for resident. -mattress protector on bed to prevent skin breakdown from incontinence. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-encourage resident with favorite items including coffee and good smelling soap. During continuous observation on 4/22/25 at 1:46 a.m. R23 was sitting on the edge of his bed in his room, eating lunch on his bedside table. His sheets had a large yellow/brown ring around him and there was an extremely strong odor of urine upon opening the door. -2:20 p.m. same as above, no staff have entered R23's room. -2:55 p.m. R23 put his call light on, licensed practical nurse (LPN)-A entered the room and asked R23 what he needed. He asked her to remove his meal tray and LPN-A stated Do you need anything else? He responded No. LPN-A removed the tray from his room, shut, the door and walked back down to the nurses station. LPN-A did not offer to toilet or change R23's clothing or bed sheets. -3:24 p.m. an unknown male entered R23's room and removed his water pitcher. -3:46 p.m. same, no staff have entered his room. -3:55 p.m. the same unknown male entered his room with a water pitcher, set it down on R23's bedside table and left the room. -4:05 p.m. R23 put on his call light and nursing assistant (NA)-B entered his room. R23 asked her to remove the water pitcher from his room. NA-B did not offer to toilet, check/change R23's brief, and/or sheets before exiting the room. R23's documentation under the toileting task in PointClickCare (computer system) indicated R23 had been toileted 3 times on 4/22/25 and the results were as follows: -05:29 (5:29 a.m.)-incontinent -10:14 (10:14 a.m.)-incontinent -18:28 (6:28 p.m.)-did not void The documentation lacked any indication R23 had been offered to toilet or had his brief checked/changed for approximately 8 hours. During interview on 4/22/24 at 4:08 p.m. NA-B verified the strong urine odor in R23's room and the yellow ring on his sheets, stating that he often refused to let staff change him. NA-B stated even if a resident refused cares, staff are still expected to re-approach and offer to toilet them every 2 hours. Refusals should be documented each time the resident refused cares and not just one overall refusal for the entire shift. During interview on 4/23/25 at 12:58 p.m., NA-C stated NA's were responsible for completing rounds every 2-3 hours in which they would offer to toilet, check/change, and/or re-position residents. If a resident refused, they would re-approach, have another staff member try to encourage the resident, let the nurse know, and document the refusal. Even if the resident refused care, the NA's were still expected to offer every 2-3 hours and document each refusal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/23/25 at 1:07 p.m., NA-D stated NA's were responsible for completing rounds every 2 hours in which they would offer to toilet, check/change, and/or re-position residents. If a resident refused, they should re-approach, try another staff member, report it to the nurse, and document the refusal. Even if the resident refused care, the NA's were still expected to offer every 2 hours and document each time the resident refused. During interview on 4/23/25 at 1:12 p.m. registered nurse (RN)-A stated nursing staff were responsible for completing rounds every 2 hours which included offer to toilet, check/change, and/or re-positioning. If a resident refused, it should be documented and nursing staff should try to re-approach or try another staff member. Nursing staff should be offering every 2 hours even if the resident refuses and documenting each occurrence. During interview on 4/24/25 at 8:27 a.m., family member (FM)-A stated when R23 lived at home he was exceptionally clean, his house was always clean, and he would not want to be sitting in urine soaked clothes or sheets. During interview on 4/24/25 at 9:47 a.m. the director of nursing (DON) stated residents should be checked every couple of hours which included offering to toilet, check/change their brief, re-positioning, and/or seeing if they need anything. If a resident refused, nursing staff were expected to re-approach or try another staff member and document the refusals. Staff were also expected to document each time the resident refused and not just document one overall refusal for the entire shift. A facility policy regarding ADL's dated 12/23/24, indicated 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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49893 Based on observation, interview, and document review the facility failed to ensure safe operating temperature of high-temperature dish washing machine. This had the potential to affect all 73 residents, staff and visitors who may use washed equipment from the facility kitchen. Findings include: During an observation and interview on 4/23/25 at 11:42 a.m., the dietary manager (DM) stated 3 empty dish racks are sent through the dish machine prior to actual dirty dishes to ensure proper operating temperatures. Proper wash temperature should be 150-degrees and proper rinse temperature should be 180-degrees. The DM sent 3 empty dish racks through and noted the wash and rinse temperature were both approximately 140-degrees. The DM sent 3 more empty dish racks through and continued to get 140 degrees for wash and rinse. The DM stated the dish machine has a booster that increases the temperature to the proper temperature. The DM noted there was a flashing red light on the booster that normally does not flash. Temperatures are logged on log sheet. The DM noted dietary aide (DA)-A documented a wash temperature of 150 degrees and rinse temperature of 180 degrees. The DM stated she would let maintenance know the dish machine was not at operating temperature. During interview on 4/23/25 at 12:05 p.m., DA-A verified checking the temperatures on the dish machine in the morning of 4/23/25. DA-A stated prior to running the dish machine, dishes are separated and then sent through the machine. The temperature is taken as the machine is running with the dishes in it. DA-A stated the temperature that morning was 150 to 180 degrees. DA-A pointed to first dial on machine labeled final rinse and stated that dial measured 150 degrees. DA-A pointed to the second dial labeled wash and stated the temperature was 180 degrees. When asked what the correct temperatures are, DA-A stated 150 to 180 and if they are higher we have to call somebody. During observation on 4/24/25 10:09 a.m., the DM ran 2 empty trays through dish machine and verified wash temp was 154 degrees and final rinse temp was 185-degrees. A facility policy titled Ware washing-mechanical and Manual-food and Nutrition reviewed 3/27/25 indicated: - check compliance for wash and rinse cycles each meal service. High temp-Wash 150-185 degrees Fahrenheit depending on type of machine. Rinse 150-180 degrees Fahrenheit depending on type of machine. - If temperatures/chemicals are outside acceptable parameters, employees notify the DFN, senior living dining director or maintenance before proceeding with ware washing. -Per the food code, when hot water mechanical ware washing is in use, and irreversible registering temperature indicator shall be readily accessible for measuring the surface temperature to ensure that 160 degrees Fahrenheit is reached in the rinse cycle.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 44647 Based on observation, interview and record review the facility failed to ensure appropriate personal protective equipment was used when separating soiled laundry and ensure resident's clean clothing was transported in a way to prevent dust and dirty to collect. This had the potential to impact all 73 residents who reside in the facility. Findings include: An observation on 4/21/25 at 11:38 a.m., laundry aide (LA)-A was pushing a large metal cart down the hallway. The cart contained multiple shirts that were on hangers. The clothing was uncovered. An observation on 4/22/25 at 11:20 a.m., LA-A was delivering clean resident clothing to rooms. A large metal cart with multiple hanging shifts were not covered. LA-A took off a few shirts, hung them on her arm and then took off a few more and carried those by hand into a resident room. An observation of the laundry room on 4/23/25 at 10:54 a.m., LA-A stated bins of soiled resident clothing and linens were sent down each shift. The laundry was then sorted into piles of shirts, pants, towels, sheets, blankets. The laundry was then done from there. When in the soiled clothing area of the laundry room, there was no PPE observed to be close by. When interviewed on 4/23/25 at LA-A stated gloves were the only PPE used for sorting the soiled clothing and linen items. LA-A further stated that was how they were taught when started. LA-A further stated there was potential for the soiled items to touch their clothing if not protected and further stated their scrubs (staff clothing) were not worn two days in a row. When interviewed on 4/23/25 at 2:30 p.m., the Infection Preventionist (IP) stated sorting soiled items required standard precautions and gloves. The IP was not sure if staff were required to wear a gown during sorting and would need to further investigate. Furthermore, the IP stated delivering laundry was a clean task and did not require PPE and the clean laundry was transported uncovered. When interviewed on 4/24/25 at 9:24 a.m., the Ancillary Department Manager (ADM) expected staff to wear gloves when sorting soiled laundry. The ADM was not sure if a gown was necessary. Furthermore, he expected all clean laundry to be covered during transport and delivery. ADM stated those metal carts were not laundry carts and therefore had no covers. ADM was working on getting an actual clothing cart that had a cover for the residents clothing. A facility policy titled Laundry Resource Policy revised 8/30/2024, directed staff to wear the appropriate PPE and at a minimum a disposable apron and gloves upon entering the soiled laundry area. Furthermore the policy directed staff to transport and store clean clothes in a way to reasonable protect them from dust and soil. Clean linen carts were to be covered at all times during storage and distribution.