STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Woodland	100 Buffalo Hills Lane Brainerd, MN 56401

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** Based on observation, interview and document review, the facility failed to ensure staff responded to resident request for toileting assistance in a timely manner for 1 of 4 residents (R23) reviewed for falls. This resulted in actual harm for R23 who fell while attempting to transfer independently, resulting in a head laceration which required emergency medical care. The facility implemented corrective action prior to the survey, therefore, the deficient practice was issued at past non-compliance. Findings include: R23's admission Minimum Data Set (MDS) dated [DATE], identified R23 had intact cognition. R23 was occasionally incontinent of bladder, continent of bowel and required maximum assistance to transfer and toilet. R23 was unable to ambulate. R23's care plan dated 4/1/25, identified R23 was at risk for falls related to activity intolerance. A goal was listed for R23 to be free of injury. Intervention included to allow R23 to make position changes slowly due to orthostatic blood pressure changes. A second intervention was added on 6/2/25, which directed staff to ensure R23 was wearing appropriate footwear. The care plan identified R23 had a self care deficit and required assistance of one to transfer and toilet. Interventions included to transfer R23 with assist of one and a mechanical stand aid and to toilet every three hours. A progress note on 5/29/25, identified R23 was found lying on the floor of her room next to her recliner. R23 had a large laceration to her forehead and R23 was sent to the emergency room to be evaluated. R23 stated she was going to go to the bathroom when she fell. R23 did not have shoes or gripper socks on at the time. Her call light was utilized prior to her fall and staff reported R23 was told she was next in line for assistance. R23 returned from the emergency room at 11:28 p.m. with eleven sutures to the laceration at the center of her forehead and purple bruising started to appear. R23's Fall Scene Huddle Worksheet dated 5/29/25, identified R23 was found on the floor in her room at 7:55 p.m., after having tried to self transfer. R23's recliner was all the way up in the elevated position and R23 was wearing socks on her feet. R23 was incontinent of urine and stated she had to go to the bathroom. Staff had offered to assist R23 to use the bathroom prior to supper and had declined the need. R23 was last toileted at 2:23 p.m. Nursing assistant (NA)-C last checked with R23 at 6:37 p.m. and notified R23 she would be the next resident to be assisted. The Summary Call Data by Room dated 5/26/25, identified identified R23 had put on her call light at 7:18 p. m. and the call light was turned off 38 minutes later when she was found on the floor. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	R23's Resident Event Abstract dated 5/29/25, identified an unobserved fall had occurred. R23 had stated she was going to go to the bathroom. R23's call light had been used prior to the fall and staff reported they had told R23 she would be next to be assisted to the bathroom and get ready for bed. On 6/1/25, at 5:10 p.m. R23 was seated in a wheelchair in her room, waiting for supper service. R23 had a laceration on the center of her forehead from her hairline to above her eyebrows that had sutures holding the edges together. Bruising was also noted surrounding the laceration. R23 stated she had fallen a few days before and hit her head on the bedside table. During interview on 6/2/25, at 3:29 p.m. NA-A stated she worked the evening of 5/29/25. She remembered it had gotten really busy with all the resident call lights. R23 had put her call light on but it had just been so busy that evening. During interview on 6/2/25, at 3:30 p.m. NA-B stated R23 would always ring her call light to go to the bathroom and at times staff would tell her they would be back in just a minute and R23 would wait. NA-B had never seen R23 attempt to take herself to the bathroom. When interviewed on 6/2/25, at 3:37 p.m. trained medication assistant (TMA)-A stated R23 would put on her call light when needed to use the bathroom and at times staff would tell her they would be back in a minute and R23 would always wait for staff to return. TMA-A had never known R23 to make self transfer attempts. During interview on 6/2/25, at 4:30 p.m. NA-D stated R23 needed assistance to go to the bathroom and was always continent of urine. R23 would ring her call light when needed to go to the bathroom and sometimes, would wheel to the doorway to look for help to the bathroom, if she was in her wheelchair. NA-D heard R23 had to wait a long time for assistance to the bathroom that evening and finally just tried to go on her own. When interviewed on 6/2/25, at 4:57 p.m. registered nurse (RN)-A stated she was working on the evening R23 had fallen. R23 had put on her call light and the NA went in and told her she would be the next to be assisted to bed and then they found her on the floor. R23's recliner was fully upright and RN-A thought she had been trying to stand and fell. Staff asked her before and after supper if she had wanted to use the bathroom and she had declined. R23 was not able to bear weight and had regular socks on, not gripper socks. RN-A assessed R23's injury and had sent her to the emergency room to be evaluated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During interview on 6/3/25, at 12:00 p.m. the director of nursing (DON) stated she had reviewed the facility video the night of R23's fall and spoken with staff who worked that evening. Staff entered R23's room and told her she was next to be assisted to bathroom and bed; however, staff assisted two other residents to bed first. The DON checked to see who the two residents were that were assisted before R23 and both residents had behaviors of anxiety, hollering out and were a high fall risk, so the staff put them to bed first. In the meantime, R23 had decided she could not wait and attempted to go herself. The DON reviewed the incident with all the NA's involved and provided education that call lights were a priority over putting residents to bed and the importance of toileting residents when they requested it. The DON stated she had also educated staff at shift change to approach R23 more directly when attempting to assist her to the bathroom instead of just asking. When a staff member saw a resident call light on, they were to check in frequently with the resident and/or get on their walkie's when a call light was on and needed to be addressed and request help. The staff on other wings needed to answer call lights and help out. During the fall investigation it was determined the the cause of R23's fall was because the call light was not addressed timely. Staff had checked in with her and told her they would be back to assist but did not get back to her timely. The staff were educated on answering call lights promptly and responding immediately to resident's request to be assisted to the bathroom. The facility' corrective actions were confirmed through a sample of other residents reviewed for falls, including R23, and verbal interviews with staff and management to affirm education was completed. R23's medical record was reviewed and verified R23 had been comprehensively assessed for fall risk, and the IDT review process was being completed since R23's fall. There were no other concerns identified regarding falls during the onsite survey. The facility policy Fall Prevention and Management dated 4/8/25, directed staff to care plan appropriate interventions to prevent falls and communicate fall risks and interventions to prevent a fall before it occurred. The facility policy Call Light dated 7/29/24, identified a purpose to ensure residents always had a method for calling for assistance and to promptly answer resident's call lights. When a resident's call light was observed, staff were to go to the resident's room promptly and respond to the resident's request as soon as possible.