STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Bethany	804 Wright Street 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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to create an individualized discharge care plan, to develop interventions to meet the resident's discharge goals and needs to ensure a smooth and safe transition from the facility to the post-discharge setting, for 1 of 3 residents (R3) reviewed. Findings include: R3's quarterly Minimal Data Set (MDS) dated [DATE], indicated R3 had diagnoses of heart failure, respiratory failure, and was cognitively intact. Further, assessment indicated there was an active discharge plan in place for R3 to return to the community and a referral had been made to the Local Contact Agency. R3's care plan dated 3/28/24, lacked evidence of a comprehensive discharge plan to address the goals for care, treatment preferences, identify needs that must be addressed before discharge, interest in and any referrals made to the local contact agency, as well as identifying post-discharge needs such as nursing, therapy services, medical equipment or modifications to the home, or activities of daily living (ADLs) assistance. On 6/12/24 at 1:25 p.m., social services (SS)-A stated discharge planning started the day the resident was admitted to the facility and the planning continues to be in progress during the resident's stay at that facility. Further, SS-A stated she does not add discharge planning into the resident's care plan but keeps the information in my brain. On 6/12/24 at 4:27 p.m., attempt to interview registered nurse (RN)-E was unsuccessful. On 6/12/24 at 4:38 p.m., director of nursing (DON) stated SS would be expected to develop a comprehensive discharge plan in the resident's care plan that would include the resident's wishes, desires, plan, and goals. DON confirmed R3 did not have a discharge plan in her care plan. On 6/12/24 at approximately 4:38 p.m., a policy related to discharge planning was requested, but facility failed to provide a copy.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview, and document review the facility failed to ensure physician treatment orders were followed for 1 of 3 (R2) residents reviewed for pressure ulcers. Findings include: R2's quarterly Minimal Data Set (MDS) dated [DATE], indicated R2 had diagnoses of pressure ulcer of left buttock, pressure ulcer of the sacral region and was cognitively intact. R2's Wound Data Collection dated 6/6/24, indicated the wound was in the peri-anal area which originally started as a moisture associate skin injury. The wound measure 5 centimeters (cm) long by 5 cm width and depth carried due to tunneling at 3:00 measuring 3 cm and tunneling between 12:00 and 1:00 measured 9.5 cm. Per wound care nurse at the hospital there was necrotic tissue on the distal area of the wound. R2's Order Summary Report dated 6/6/24, indicated wound care instructions for R2's sacral wound included: cleanse wound with saline and pat dry, wet-dry dressing changes utilizing sterile saline, ensure tail for easy removal, and apply ABD and secure with Medipore tape. On 6/12/24 at 10:44 a.m., registered nurse (RN)-A knocks and enters R2's room to completed R2's wound care. RN-A was observed to wash her hands in the bathroom, she then applied an isolation gown and gloves. RN-A stated she removed the old dressing from the wound on R1's bottom placed into the garbage can along with her soiled gloves. RN-A washed hands in the bathroom and applied clean gloves. RN-A then cleaned the wound with saline and gauze pad and RN-A stated the wound looked like it had improved with no signs of infection, no necrotic tissue noted, and no odor. RN-A removed soiled gloves into the garbage can and washed hands in the bathroom and applied clean gloves. RN-A soaks gauze with sterile saline and packs the gauze into the wound using a sterile cotton swab and left a tail of gauze out. RN-A removes gloves into the garbage and washed hands in the bathroom and applied clean gloves. RN-A soaks cotton swab with sterile saline and cleans around the wound on the tissue. RN-A again removed soiled gloves and washes hands in the bathroom. RN-A stated R1's wound care was complete and assisted the nursing assistant with getting R1's incontinent brief back on. Further, when questioned about R2's treatment order RN-A went to R2's wound supply drawer and stated staff do not cover the wound or use tape, leave as is with the gauze. At 11:03 a.m., RN-A entered RN-D's office and questioned about the pad and tape over the gauze. On 6/12/24 at 11:03 a.m., RN-D confirmed R2's wound needed to be covered with an ABD pad (abdominal pad used as a secondary dressing over wounds that discharge fluid). RN-D knocks on R2's door and explained RN-D needed to cover the wound, which R2 was compliant. RN-D applied gown and gloves and places the ABD pad over the wound and applied tape to both sides. RN-D stated the wound was open and we are trying to protect it. RN-D stated the wound had improved. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 11:16 a.m. RN-A stated she typically did not work on R2's unit but staff were expected to review the resident's treatment administration record (TAR) for the wound treatment order. RN-A confirmed at the start of R2's wound treatment when she removed the old gauze from R2's wound, the wound was not covered with an ABD pad or taped. Further, RN-A stated R2 could have removed the tape himself and RN-A did not recall any concerns regarding R2's wound or him removing the dressing through report from previous shift. On 6/12/24 at 11:28 a.m., R2 denied removing any dressing from his wound, and did not remove any gauze or tape. R2 confirmed the previous nurse did not cover or put tape on the wound from the previous day. On 6/12/24 at 4:38 p.m., director of nursing (DON) indicated staff were expected to read each resident's wound treatment order each time they do the treatment. DON stated if the order was complex the staff could write the order on a piece of paper to bring with them while they complete the treatment or if there were multiple steps to the treatment order the nurse could print the order as well. On 6/12/24 at approximately 4:38 p.m., a pressure wound policy and treatment order policy was requested, however facility failed to provide a copy.

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F 0689 Level of Harm - Minimal harm or potential for 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** 43083 Based on interview and document review the facility failed to provide adequate supervision for 1 of 3 residents (R1) reviewed, who was cognitively impaired and arrived at an outpatient appointment unaccompanied and was noted to be disorientated and exhibiting aggressive behaviors. Findings include: R1's quarterly Minimal data set dated [DATE], indicated R1 had a diagnosis of Alzheimer's Disease and had severely impaired cognition. Further, R1's MDS revealed R1 exhibited physical and verbal behavioral symptoms. R1's care plan as of 6/11/24, indicated R1 had impaired cognition or impaired though process related to Alzheimer's disease and was exhibited by forgetfulness, confusion and often refusals of care. R1 required assistance by staff for all activities of daily living (ADLs) which included bed mobility, dressing, toileting, and transfers. Further, R1's care plan revealed R1 would exhibit behaviors of resistive to cares and screaming at others and directed staff to provide consistency in care and maintain consistency in timing of ALDs, caregivers, and routine. R1's progress note dated 6/5/24, indicated a nurse from the orthopedics clinic called the facility and stated R1 was not orientated to person and could not verify was he was. After the facility verified R1's identity, R1's vitals were obtained, and his blood pressure was noted to be 80/50 and had a temperature of 99.5. Orthopedic nurse stated R1 was being transferred to the emergency department for further assessment. On 6/12/24 at 8:40 a.m., R1 was observed sitting in his wheelchair in his room. R1 could not recall going to an orthopedic appointment at the clinic independently. On 6/12/24 at 11:16 a.m., registered nurse (RN)-A stated R1 had impaired cognition exhibited by confusion and would get ornery and would swing, grab, and hit at staff. RN-A stated R1 would not be able to make his own medical decisions and his daughters would go with to all appointments. Further, RN-A stated if a resident had impaired cognition, confused, and were not able to be accompanied by either a relative or friend to an appointment the resident would not go to the appointment and facility would find alternative ways such as if the outpatient service could be provided at the facility. On 6/12/24 at 11:33 a.m., nursing assistant (NA)-A stated R1 was confused, couldn't understand staff, and have a fluent conversation with staff as his answers would not be appropriate to questions. NA-A stated due to R1's cognition and behaviors such as hitting and kicking, R1 would not be safe to independently go out into the community by himself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 11:51 a.m. family member (FM)-A stated R1's had a scheduled orthopedic appointment for an injection to R1's knee and the nurse from the clinic called FM-A and reported R1 was confused and could not recall his last name, date of birth, or the reason for his appointment. FM-A stated the facility staff were aware family would not be there as FM-A was not in the state and FM-A was told staff were not able to attend the appointment with R1, but FM-A was unsure why. FM-A confirmed R1 had went to the appointment unaccompanied and without an advocate there for him. On 6/12/24 at 1:06 p.m., RN-B stated R1 was frequently confused, and short-term memory and safety awareness were impaired. RN-B stated R1 had two daughters who were Power of Attorney and would assist in any medical decisions. Further, RN-B stated R1 would not be safe to be unaccompanied out in the community as he could injury himself or someone else if something set him off due to R1 exhibiting some physical aggression. RN-B confirmed on 6/5/24, R1 had an appointment and was being transported by Medi-van (transportation service company) unaccompanied. RN-B stated as a floor nurse they assist with getting the resident ready for the appointment and get any paperwork ready that may be needed, but the floor nurse would not have been the one to schedule the appointment, transportation, or contacting a family or friend to assist the resident with the appointment as that would be role of the health information staff. On 6/12/24 at 1:22 p.m., health information (HI)-A stated she would schedule all appointments for the residents on the unit R1 was currently residing on. HI-A stated she was not responsible for assessing and determining if a resident was safe and appropriate to attend an appointment unaccompanied. HI-A stated she would contact the first emergency contact listed for the resident and if a resident would go unaccompanied HI-A stated she would consult with the nurse manager on the unit especially if the resident exhibits behaviors. Further, HI-A stated R1 had an orthopedic appointment that was scheduled, and HI-A spoke with one of R1's daughters, unsure which one, in person and had asked if the daughter was accompanying R1 to the appointment which daughter stated she was not. HI-A did not consult with R1's nurse manager about the appointment. On 6/12/24 at 2:20 p.m., RN-C stated facility process for resident appointments was the HI staff would notify family and ask if transportation would need to be arranged and give the resident a green slip of paper that would have detailed information regarding the appointment including time, where, and what they will have done. RN-C stated if the resident was cognitively impaired, and family was unable to accompany the resident to the appointment the facility would attempt to arrange the appointment for when family would be available to accompany the resident or if the clinic was familiar with the resident and their doctor was aware of the resident then the resident would be able to go to the appointment unaccompanied. Further, RN-C stated R1 had some confusion, safety awareness was non-existent, and R1 had exhibited physically aggressive behaviors towards staff. RN-C stated FM-A made an orthopedic appointment for R1 and had asked the facility to set up transportation for R1. RN-C stated the facility was not aware family was not accompanying R1 to the appointment and RN-C had not contacted the clinic to inform them about R1's behaviors. In addition, RN-C stated R1 will no longer be able to go to appointment unaccompanied as the facility learned from the mistakes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24, at 4:15 p.m., director of nursing (DON) stated if a resident could advocate and was alert and orientated, they would be able to go to an appointment unaccompanied, however, if the resident was not then they would require to be accompanied by family or friend. If a family or friend was unable to accompany a cognitively impaired resident, then the facility would attempt to arrange services for in house at the facility. DON stated R1 had impaired cognition and had a diagnosis of dementia, and R1's behaviors had been challenging and violent at times. Further, DON stated she was aware R1 had went to an orthopedic appointment unaccompanied by family but was not aware until the nurse from the clinic called the facility to speak with the nurse on his unit. DON stated if HI staff were aware family was not accompanying R1 then the appointment should have been canceled or in urgent situations DON stated she would accompany a resident. In addition, DON stated she had not investigated the incident and has not discussed where the facility's process had failed with HI staff or R1's nurse manager. On 6/12/24, at approximately 4:15 p.m., policy regarding appointments and/or supervision was requested but not provided.