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	02/14/2025

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview and document review, the facility failed to ensure acute, potentially distressing psychoactive symptoms were recorded and non-pharmacological interventions were attempted or recorded to ensure efficacy of as-needed (PRN) psychotropic medication for 2 of 3 residents (R1, R3) reviewed for unnecessary medications. Findings include: R1's significant change Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included depression, anxiety, and R1 was cognitively intact. Identified R1 did not exhibit any behaviors. R1's care plan revised on 2/12/25, indicated R1 had a potential mood problem related to depression and anxiety disorder and directed staff to provide encouragement/assistance/support to maintain as much independent and control as possible, for relaxation: keep on classical music, essential oils (lavender), keeping clean (hand washing), lotion, and foot massage. Further, R1's care plan revised 2/11/25, indicated R1 had a behavioral symptom related to anxiety and depression and would frequently refuse baths, medications, and daily cares and directed staff to attempt non-pharmacological interventions which included 1-1 visits, classical music, massage, repositioning as needed, and ask if R1 needed toileting or to be changed. R1's Medication Administration Record (MAR) for February 2025, indicated R1 had a physician order for Lorazepam (an anti-anxiety medication) 0.125 milliliters (ml) every 4 hours as needed for anxiety related to anxiety disorder. Further, MAR revealed R1 received Lorazepam twice on 2/9/25, and once on 2/10/25. R1's progress notes revealed the following: -On 2/9/25 at 6:48 a.m., Lorazepam was administered at 7:49 a.m. Lorazepam and was documented as effective. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/9/25 at 4:05 p.m., R1 was calling out constantly at beginning of shift for help and pain medications and staff helped her and nurse gave some Ativan (Lorazepam) to help with calling out and anxiety, due to not being able to have pain medication yet. This was successful and resident was able to rest for a while. Resident was calling out in sleep throughout shift. There had been times she was calling out and not remembering she can't stand or use toileting. -On 2/9/25 at 5:50 p.m., Lorazepam was administered per resident request. At 10:42 p.m., Lorazepam was documented as effective. -On 2/10/25 at 12:30 p.m., Lorazepam was administered and at 3:33 a.m. Lorazepam effectiveness was documented as unknown. -On 2/10/25 at 9:36 a.m., R1's daughter called and very mad about R1 being full of bowel last night. Daughter said she was snowed when she was there and unable to converse with her. Does not want Ativan (Lorazepam) given again unless heard from her or consult her. R1's progress notes lacked anxiety symptoms R1 was exhibiting at the time the PRN Lorazepam was administered, as well as lacked evidence of non-pharmacological interventions attempted prior to administration. R3's admission MDS dated [DATE], indicated R3 had diagnoses of anxiety disorder, depression, and R1 had moderately impaired cognition. Further, R1 did not exhibit any behaviors. R3's care plan revised on 2/4/25, indicated R1 had orders for Ativan (Lorazepam), however R3's care plan lacked non-pharmacological interventions for staff to implement when R3 would be exhibiting symptoms of agitation and/or anxiety. Further, R3's care plan identified R1 had depression related to admission to facility with hospice services and R3's care plan directed staff to implement brief visits to her room when she was awake. R3's MAR for February 2025, indicated R3 had a physician order for Lorazepam 0.5 mg (milligrams) every 6 hours as needed for agitation or anxiety related to anxiety disorder. Further, MAR revealed R1 had received Lorazepam one time on 2/2/25, twice on 2/3/25, and once on 2/11/25. R3's Progress Notes revealed the following: -On 2/2/25 at 7:34 a.m., Lorazepam was administered and at 7:41 a.m. Lorazepam was documented as ineffective due to R3 vomiting. -On 2/2/25 at 2:34 p.m., Resident uncomfortable at start of shift. Resident stated I haven't slept for two nights. I am just so worried about death. She remains restless and worried. Writer administered PRN Lorazepam 0.5 mg; patient regurgitates pill. -On 2/3/25 at 9:14 a.m., Lorazepam was administered and at 10:16 a.m., Lorazepam was documented as effective. -On 2/3/25 at 3:17 p.m., Resident was crawling out of bed this morning. PRN Lorazepam was given when resident was agitated. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/3/25 at 3:30 p.m., Lorazepam was administered and at 8:08 p.m., Lorazepam was documented as effective. -On 2/11/25 at 9:57 a.m., Lorazepam was administered and at 12:59 p.m., Lorazepam was documented as effective. R3's progress notes lacked agitation or anxiety symptoms R3 was exhibiting at the time the PRN Lorazepam was administered, as well as lacked evidence of non-pharmacological interventions attempted prior to administration. During an interview on 2/13/25 at 11:09 a.m., family member (FM)-A stated R1 was just prescribed Lorazepam recently by hospice and FM-A stated R1 was given a few doses in less than 24-hour period without the facility attempting to meet R1's needs and/or non-pharmacological interventions prior to the administration. During an observation on 2/13/25 at 1:51 p.m., R1 was observed lying in bed: appeared to be comfortable and content and no anxiety symptoms were noted. During an observation on 2/14/25 at 9:17 a.m., R3 was observed to be lying in bed, appeared to be sleeping with her eyes closed, appeared comfortable and no agitation or anxiety symptoms noted. During an interview on 2/14/15 at 11:42 a.m., nursing assistant (NA)-A stated she had not observed any side effects from medications for R1 and stated R1 had anxiety related to family not visiting often and staff were directed to offer her a cold pack for distraction, oils, and music. Further, NA-A stated R3 had not exhibited any agitation or anxiety symptoms that she had observed. During an interview on 2/14/25 at 12:06 p.m., registered nurse (RN)-A stated R1 exhibited behaviors of calling out when she was needing something rather than using the call light. RN-A stated R1 had an order for PRN Lorazepam and RN-A had administered the PRN medication due to resident calling out and non-pharmacological interventions of pain control, repositioning, and bed bath were unsuccessful. RN-A stated after the administration of PRN Lorazepam, R1 appeared comfortable and was not anxious. Further, RN-A stated if a resident was on hospice, staff would be expected to ensure the resident was comfortable, and attempt non-pharmacological interventions, which would be listed and identified in the resident's care plan, prior to administered a PRN psychotropic medication. In addition, RN-A stated the facility's EMR system lacked a place for staff to document interventions that were attempted. During an interview On 2/14/25 at 1:39 p.m., RN-E stated R3 was on hospice and RN-E had administered R3's PRN Lorazepam 2 or 3 times due to either family's request or R3 yelling out and hallucinating about something that was not real. RN-E stated R3 responded well to the PRN Lorazepam and would calm down and appear comfortable. Further, RN-E stated staff were expected to try least restrictive methods for addressing anxiety or agitation, such as non-pharmacological interventions of snacks, television, music, or calling family, prior to administering a PRN. RN-E stated staff did not chart in the resident's EMR non-pharmacological interventions that were attempted. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/25 at 2:36 p.m., RN-B stated R1 had an order for PRN Lorazepam that RN-B had administered one time due to R1 being anxious and RN-B attempted to comfort R1 by sitting with her and visiting and offering to call R1's family prior to administering the PRN. RN-B stated R3 also had a PRN order for Lorazepam but had never administered the medication for R3 before. Further, RN-B stated staff were expected to attempt non-pharmacological interventions prior to administering a PRN psychotropic medication and document in the EMR what was attempted and what was effective or not effective. On 2/14/25 at 3:08 p.m., RN-C stated she would observe the resident and if a resident appeared to be anxious, restless, or uncomfortable she would administer a PRN psychotropic medication. RN-C stated she would attempt deep breathing exercise with the resident prior to administering the PRN psychotropic, as that would be an intervention for nursing, but no other non-pharmacological intervention would be attempted. RN-C stated R3 was disoriented and would often attempt to crawl out of her bed. Further, RN-C stated she had administered R3's PRN Lorazepam due to R3 yelling and attempting to crawl out of bed and appeared to be very anxious but confirmed she had not attempted any non-pharmacological interventions prior to administration of the PRN. On 2/14/25 at 3:33 p.m., RN-D stated staff would be expected to attempt non-pharmacological interventions such as snack, distraction, calling family, activities, or a walk prior to administering a PRN psychotropic medication. RN-D stated person-centered interventions would be listed in each resident's care plan in the EMR for staff to reference. Further, RN-D stated staff would be expected to document in the resident's EMR regarding the symptoms the resident was exhibiting and what interventions were attempted prior to administering the PRN medication. In addition, RN-D confirmed R1 and R3's EMR lacked evidence of the signs the residents were exhibiting and what non-pharmacological interventions were attempted prior to administering their PRN psychotropic medication and R3's care plan lacked interventions related to R3's agitation and anxiety. On 2/14/25 at 4:13 p.m., director of nursing (DON) stated staff would be expected to chart in the resident's EMR non-pharmacological interventions such as redirection, snacks, toileting, etc., prior to giving a PRN psychotropic medication. DON stated staff should also document the reasoning or rationale for the PRN psychotropic medication use and what signs the resident was exhibiting at the time of the administration and then the effectiveness. DON stated each resident would have person-centered non-pharmacological interventions in their care plan for staff to reference. Review of facility policy titled Medication: Administration Including Scheduling and Medication Aides revised 5/21/24, indicated when PRN medications were administered, staff were directed to evaluate and document the efficacy of the medication. However, the policy lacked staff direction on documenting reasoning for administering a PRN psychotropic medication as well as attempting and documenting non-pharmacological interventions prior to the PRN administration.