

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Mountain Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 745 Basinger Memorial Drive Mountain Lake, MN 56159	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify the resident representative and the medical provider following discovery of a deep tissue injury (DTI) (pressure injury where damage occurs to the underlying tissue before becoming visible on skin surface) for 1 of 1 resident (R196) reviewed for notification of change.</p> <p>Findings include:</p> <p>R196's Face Sheet printed 7/2/25, included diagnoses of cerebral infarction (stroke), pressure ulcer of sacral region unstageable (a type of pressure injury where the depth of wound cannot be determined because the wound bed is obscured by slough or eschar [black or brown layer of dead tissue]).</p> <p>R196's admission (MDS) assessment dated [DATE], indicated R196 had intact cognition, understands and is understood, and had no behaviors. R196 required partial to moderate assist for bed mobility and transfers and substantial to maximum assist for walking 10 feet. R196 had no known weight loss or gain or chewing/swallowing issues. R196 was not at risk for pressure ulcers (PU) and had no current PU's but did have skin tears present.</p> <p>R196's care plan dated 4/24/25 included impairment to skin integrity on left lower leg, bruising, small openings; appears to be trauma related; skin is also very fragile with bruising upon admission. Interventions included keep skin clean and dry, use lotion on dry skin. Weekly skin observation by licensed nurse. R196's plan of care was updated on 5/9/25, to include the resident has a suspected DTI with open area of coccyx related to immobility and resident prefers to lie on back in bed and spend a large amount of time in wheelchair. Interventions included low air loss air mattress; Roho cushion (used to prevent/treat pressure ulcers PU's); encourage resident to reposition side to side in bed; encourage and assist to turn and reposition at least every 2-2.5 hours when in bed related to current PU and high risk for further skin injury; encourage resident not to be in wheelchair longer than 3 hours if can be avoided.</p> <p>A Skin Assessment by licensed practical nurse (LPN)-A dated 5/7/25, included coccyx and buttocks are reddened and top of coccyx has a dark red area that is still blanchable.</p> <p>A Wound Data Collection by registered nurse (RN)-A dated 5/9/25, included initial data collection on the coccyx. No dressing present with area dark purple surrounding open area; red and excoriated skin distal to open area with bleeding this a.m.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 245549	Facility ID: 245549 If continuation sheet Page 1 of 10

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Wound RN Assessment by RN-A 5/9/25, included physician was notified regarding wound status. A provider order signed by nurse practitioner (NP)-B included wound care for coccyx: cleanse area well and pat dry. Apply skin prep to surrounding skin. Warm 2x2 hydrocolloid dressing (2 layer dressing that absorbs drainage to form a hydrated gel over the wound to create a moist environment to promote healing) in hands a few seconds and apply dressing over wound. One time a day every 3 days for coccyx wound.</p> <p>The electronic medical record (EMR) did not include notification of family until 5/21/25, by RN-A. A progress note 5/21/25, by RN-A included wound was open on coccyx, and R196 had decreased progress in therapy over past week, increased weakness, decreased response during conversation and decreased appetite. Explained that condition of wound has quickly deteriorated and may need procedures that facility wound nurse is not able to complete. Explained that wound condition suggests further deep tissue injury under visible wound surface that may lead to bone resulting in infection, sepsis, and death. But also explained that even with a wound clinic treatments/routine visits, the potential of wound healing without adequate nutrition (calories, protein, vitamins/minerals) would still be slim. FM-B verbalized understanding; RN-A explained that all of the above information has also been discussed with R196 but R196 was not able to give an answer on how she would like to move forward.</p> <p>On interview 7/1/25 at 3:18 p.m., family member (FM)-B indicated the family was not notified until 5/18/25, when her family member was at the facility and saw the wound. FM-B stated a phone call was made to the facility on 5/22/25, and RN-A ensured the facility had the wound under control. FM-B stated she requested to be notified if the wound worsened prior to a wound care clinic appointment on 5/29/25, but was never notified. FM-B stated when R196 arrived at the wound care clinic, the wound had worsened to the point R196 had to be hospitalized because the wound was infected.</p> <p>A Wound and Hyperbaric Healing Center note by NP-D on 5/29/25 at 12:30 p.m., included acute cellulitis (bacterial infection of the skin and underlying tissues) present along with unstageable sacral pressure ulcer requiring hospitalization for stabilization and planning of further care. Discussed with family that this is a very serious ulcer and prognosis.</p> <p>During interview on 7/2/25 at 10:56 a.m., LPN-A indicated she doesn't remember notifying the family or provider on 5/7/25 when the dark red spot was initially identified. LPN-A added if it wasn't documented they likely were not notified.</p> <p>During interview 7/2/25 at 11:37 a.m., RN-A stated there was no documentation family was notified until 5/21/25 regarding the coccyx wound adding the wound progressed very rapidly. RN-A stated she notified the provider on 5/9/25, regarding coccyx ulcer and got orders for treatment.</p> <p>On interview 7/2/25 at 12:16 p.m., FM-A stated a nurse (was unable to identify which nurse) contacted him about the wound initially when it was the size of a quarter and was open, when they were requesting to make an appointment with the wound care clinic. FM-A stated this was about a week before R196 went to the wound clinic (5/29/25) (could not give an exact date).</p> <p>On interview 7/2/25 at 1:14 p.m., medical doctor (MD)-C stated he was not sure when first notified of R196's wound but EMR first noted orders were given on 5/9/25.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On interview 7/2/25 at 12:58 p.m., the director of nursing (DON) stated the family and provider should have been notified when initially discovered the dark red spot on the coccyx and then again by the RN when the wound opened.</p> <p>Facility Notification Of Change policy dated 12/21/24, indicated a facility must immediately inform the resident, consult with the resident ' s physician and notify, consistent with his or her authority, the resident representative(s) when there is: 1) An accident involving the resident which results in injury and has the potential for requiring physician intervention. 2) A significant change in the resident's physical, mental or psychosocial status. 3) A need to alter treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to assess, monitor and implement pressure relieving interventions for 1 of 1 resident (R196) who developed an unstageable pressure ulcer to the coccyx (small, triangular bone located at the bottom of the spine) area.</p> <p>Findings include:</p> <p>Pressure Ulcer stages defined by the Minimum Data Set (MDS) per Center Medicare/Medicaid Services:</p> <p>Deep-Tissue Injury (DTI): Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler than adjacent tissue.</p> <p>Unstageable pressure ulcer: (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.)</p> <p>R196's Face Sheet printed [DATE] included diagnoses of cerebral infarction (stroke), pressure ulcer of sacral region unstageable (a type of pressure injury where the depth of wound cannot be determined because the wound bed is obscured by slough or eschar (black or brown layer of dead tissue), atrial fibrillation with presence of cardiac pacemaker, unsteadiness on feet and back pain.</p> <p>R196's admission (MDS) assessment dated [DATE], indicated R196 had intact cognition, understands and is understood, and had no behaviors. R196 required partial to moderate assist for bed mobility, transfers and personal hygiene and substantial to maximum assist for walking 10 feet, toileting and dressing. R196 had no known weight loss or gain or chewing/swallowing issues. R196 was not at risk for pressure ulcers (PU) and had no current PU's but did have skin tears present.</p> <p>R196's care plan dated [DATE], included impairment to skin integrity on left lower leg, bruising, small openings; appears to be trauma related; skin is also very fragile with bruising upon admission. Interventions included keep skin clean and dry, use lotion on dry skin and weekly skin observation by licensed nurse. R196's plan of care was updated on [DATE], to include the resident has a suspected DTI with open area of coccyx related to immobility and resident prefers to lie on back in bed and spend a large amount of time in wheelchair. Interventions included low air loss air mattress; RoHo cushion (used to prevent/treat pressure ulcers PU's) to wheelchair and recliner; encourage resident to reposition side to side in bed; encourage and assist to turn and reposition at least every 2-2.5 hours when in bed related to current PU and high risk for further skin injury; encourage resident not to be in wheelchair longer than 3 hours if can be avoided. R196's activities of daily living (ADL) plan of care dated [DATE] included assist of 1 with bed mobility, dressing, toileting and transfer and set up assistance with personal hygiene. R196 is able to eat independently.</p> <p>R196's Braden scale assessments (tool used to predict pressure ulcer risk) included: (high risk score of 10-23, Moderate Risk 13-14, Mild risk 15-18).</p> <p>[DATE] - Mild risk score of 18.</p> <p>[DATE] - Mild risk score of 17.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[DATE] - Mild risk score of 16.</p> <p>[DATE] - Mild risk score of 16.</p> <p>R196's Care Area Assessment for Pressure Ulcer/Skin dated [DATE], included R196 is at low to moderate risk for pressure injury. R196 ambulates with therapy and is able to reposition herself in bed or with minor assist from staff. No pressure injury present on admission however did admit with healing skin tear on lower left leg. Does have bladder incontinence with staff assist with all tasks related to toileting, transfers, clothing, incontinent pads and peri-care. R196 has intact cognition. Although she has a flat affect, she is alert and oriented and uses call light appropriately. Uses Tramadol 50mg BID due to history of compression fractures and osteoarthritis. Cerebral vascular accident (stroke) with decreased mobility and activities of daily living function and is no concerns for PU at this time; will address impaired skin due to healing skin tear.</p> <p>A progress note dated [DATE] at 12:56 p.m., registered dietician (RD)-E indicated R196 was at risk for malnutrition due to inadequate calorie intake and wounds including coccyx and buttocks reddened. R196 has not had significant weight loss but has inadequate oral intake related to recent acute stroke with variable intake with most meals at 0-50%. Will suggest discussion of possible nutrition interventions due to her history of weight loss and poor current intake at meals.</p> <p>Skin Assessments included:</p> <p>[DATE] (on admit): Sacrum is pink and intact, with right and left arm bruising present. Left lower leg bruising with multiple skin tears.</p> <p>[DATE]: Bruising and skin tears, left lower leg with healing and other bruising on bilateral lower arms, improving, face 1 cm scab present on left cheek with Band-Aid applied.</p> <p>[DATE]: Left lower leg with long bruise and small skin tear. Area cleansed and new dressing applied. Coccyx and buttocks are reddened and top of coccyx has dark red area that is still blanchable per licensed practical nurse (LPN)-A.</p> <p>[DATE]: Coccyx pink area, but no open areas. Left lower leg with several small scabbed areas 0.8 x 0.5 cm. Completed by RN-B.</p> <p>[DATE]: Coccyx - see Registered Nurse (RN) wound assessment, area with black center. Completed by RN-B</p> <p>[DATE]: Coccyx - see RN wound assessment for measurements. Area black with surrounding tissue red. Completed by RN-B.</p> <p>A Wound Data assessment dated [DATE] by RN-A included initial data collection on the coccyx. No dressing present with area dark purple surrounding open area; red and excoriated (red and inflamed showing signs of trauma or open wounds) skin distal to open area with bleeding this a.m.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Wound Data Collection form by registered nurse (RN)-A dated [DATE] included wound is 1.5 cm x 0.5 cm x 0.2 cm depth on coccyx. Moderate drainage, sanguineous (thin watery liquid that leaks out commonly seen in fresh wounds within 48-72 hours during inflammatory wound healing stages) no odor present. Wound margins with ecchymoses (skin discolorations from damaged blood vessels). Modification to interventions included repositioning/turning and wound treatment. Skin prep (protective barrier) to surrounding skin; hydrocolloid dressing (dressing made from gel-forming agent that helps to rehydrate the wound and absorb excess fluid) over wound.</p> <p>A notification to the provider, by registered nurse (RN)-A [DATE] included physician was notified regarding wound status. A provider order signed by nurse practitioner (NP)-B included wound care for coccyx: cleanse area well and pat dry. Apply skin prep to surrounding skin. Warm 2x2 hydrocolloid dressing (2 layer dressing that absorbs drainage to form a hydrated gel over the wound to create a moist environment to promote healing) in hands a few seconds and apply dressing over wound. One time a day every 3 days for coccyx wound.</p> <p>A physician visit from MD-C on [DATE] included no reported concerns from staff at the nursing facility. Skin was not assessed and no mention of coccyx wound on examination or assessment was present.</p> <p>A progress note on [DATE] at 2:59 p.m., by social worker (SW)-A included Mood/Behavior</p> <p>Note Text: 1 to 1 with res re: mood. Res was watching TV from her recliner, with a container of Boost at hand. Res was asked about her appetite; simply said, I'm not hungry. Res was asked about her long-range plan; she shrugged; indicated she didn't know if she is progressing (with therapy) or not. It seems kind of hopeless, R196 said. R196 was asked if she is purposefully not eating. There was a long silence and then R196 said, My good friend was here and she stopped eating and drinking and died after 22 days. R196 then added, I don't know if it was purposeful or not. R196 was given a little more information (verbally) about the option of stopping all intake; including the physician likely wishing to rule out depression first, and making sure the individual is of sound mind. R196 was encouraged to consider an antidepressant . She commented, My get up and go has got up and went. R196 was offered mental health professionals to talk to via tele-health. R196 looked thoughtful but did not respond. R196 was asked if she would like to discuss with her children . or her PCP .she would not respond. After considerable silence I stated I'd let her think about these options and then she said, ok, if that's what you'd like to do.</p> <p>An RN Wound assessment dated [DATE] at 12:42 p.m., by RN-A included suspected DTI, with full thickness loss. Deterioration of wound evidenced by all of necrotic tissue has opened up revealing larger wound; wound bed/margins remain dark purple in color. Increased drainage over past couple days. Debridement done using mechanical (removal of foreign material or devitalized tissue through physical means) and autolytic (use of moisture retentive dressing to cover the wound and allow devitalized tissue to self digest by enzymes present in the wound fluids). Interventions include repositioning/turning, support surfaces, friction/shear management and wound treatment. Physician was notified regarding wound status and care plan was updated. Physician notified of deterioration of wound (and overall condition) and updated on interventions that already have been and will be put into place.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Wound Data Collection dated [DATE], by RN-A included wound is 3 cm x 2 cm x 0.5 cm visible depth measurement; wound bed deep purple, suspected further deep tissue injury. Dressing present and intact with drainage. No drainage leaking around the dressing. Moist, soft edges. No complications. Resident does voice complaints of pain related to the wound and is tender to touch. Wound bed was not described. Moderate, serosanguinous drainage present with slight odor, with hydrocolloid dressing in place with large amount of drainage. Skin is macerated, deep purple wound margins extending out approx 1 cm to surrounding skin. No undermining or tunneling. Wound treatment included Calcium Alginate Silver rope packing (helps absorb moderate to heavy amounts of wound drainage); border foam cover. R196 continues with poor appetite/intakes with 5 pound weight loss since admission. Is on 4 oz house supplement BID in which she usually drinks. R196 chooses to sit up in wheelchair or recliner a majority of the day. Roho cushion to chair and low air-loss mattress applied. Physician was notified. New orders on [DATE] to include: Wound care for coccyx to include cleanse area well with wound cleanser; pat dry. Apply skin prep to surrounding skin. Pack wound bed with silver calcium alginate rope. Cover with silicone border foam dressing. Change dressing daily and as needed if becomes soiled or loose signed by NP-B.</p> <p>A progress note dated [DATE], by RN-A included wound was open on coccyx, and R196 had decreased progress in therapy over past week, increased weakness, decreased response during conversation and decreased appetite. Explained to FM-B that condition of wound has quickly deteriorated and may need procedures that facility wound nurse is not able to complete. Explained that wound condition suggests further deep tissue injury under visible wound surface that may lead to bone resulting in infection, sepsis, and death. Also explained that even with a wound clinic treatments/routine visits, the potential of wound healing without adequate nutrition (calories, protein, vitamins/minerals) would still be slim. FM-B verbalized understanding; RN-A explained that all of the above information has also been discussed with R196 but R196 was not able to give an answer on how she would like to move forward.</p> <p>A Physician Notification dated [DATE] by RN-B included R196 has wound on coccyx that is black colored. May we have a referral for the wound clinic. An order was received from CNP-F for wound care clinic and CNP also included please schedule exam of area at NH next provider rounds.</p> <p>An RN wound assessment dated [DATE] by RN-A included wound is unstageable with less drainage, odor improved, necrotic tissue slightly loose around edge, maceration improved. Damaged deep tissue now necrotic (dead tissue caused by injury, infection or lack of blood supply). Modifications include support surfaces, nutritional and wound treatment. Physician notified regarding: Requested order to change cover dressing for adequate drainage/moisture management; and will request Juven (drink to support wound healing in patient with inadequate nutrient intake) order if R196 likes Juven.</p> <p>A wound data collection tool dated [DATE] at 10:34 a.m., by RN-A included wound is 3 cm, by 2.6 cm with no depth documented. Dressing was present, and intact with drainage present but not leaking around the dressing. Surrounding tissue is pink and dry and intact. R196 has pain related to wound and is tender to touch. Slough 20%, eschar 80% (dead tissue that develops in severe wounds), moderate serosanguinous (fluids discharge light pink, thin and watery) drainage with odor present with slight foul odor improved over past 2 days. Wound margins are macerated and softened, with wrinkled tissue due to moisture. No undermining or tunneling. Dressing/Treatment: Calcium Alginate Silver rope packing and superabsorbent dressing instead of border foam. Low air loss mattress added. R196 has agreed to try Juven; if res likes supplement will obtain physician's order to give her routinely for wound healing.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A provider notification dated [DATE] by RN-A included coccyx wound continues to have some excess of moisture related to drainage; can we DC silicone border dressing and change cover dressing to superabsorbent dressing to better manage drainage/moisture until wound clinic appointment on 5/29? CNP-F responded [DATE] to discontinue silicone border use superabsorbent dressing as cover dressing to coccyx wound daily.</p> <p>A wound data collection dated [DATE] by RN-B included Coccyx wound with dressing present with drainage. There is increased drainage present and complaints of coccyx pain. RN-B answered yes to presence of possible complications, increasing area of ulceration or soft tissue infection increased, redness, swelling around the wound and increased drainage from the wound.</p> <p>A Wound and Hyperbaric Healing Center note dated [DATE] at 12:30 P.M., by NP-D included open PU to the sacrum that family states present for 2-3 weeks. Unstageable PU with cellulitis of surrounding tissue. Wound measured 6 cm length by 3.5 cm width x 1 cm of unstable etiology and located midline coccyx. Large amount of sanguineous (bright red fluid that oozes from wound mainly consisting of blood) drainage noted. Wound margins are distinct with the outline attached to the wound base. There is no granulation within the wound bed. There is a strong malodor associated with the ulcer. There is a large amount of purulent (drainage that is thick from infected wound) brown drainage noted with the cleansing. There is superficial blistering noted along the left lateral border of the ulcer. The ulcer is covered with 100% soft black eschar. Peri wound showing induration (thickening and hardening of tissue) with erythema (redness) and warmth to the touch. Discuss with FM-B that R196 does have acute cellulitis (infection) and unstageable sacral PU and will need at least hospitalization locally for stabilization and planning of further care. Discussed with family that this is a very serious ulcer and prognosis.</p> <p>R196's admission history and physical dated [DATE] by MD-G included admitted to the hospital directly from the wound care clinic for cellulitis and unstageable pressure sore of sacral area with black eschar, not treatable without extensive surgical debridement which the patient and family refuse.</p> <p>A progress note dated [DATE] by RN-A included R196 returned from the hospital PU is present upon readmission, and is unstageable, with improved erythema since hospitalization. Deterioration of wound is present as evidenced by copious amt of drainage with necrotic tissue covering wound bed. Larger dimensions since 5/23 assessment from this nurse. Hospitalization 5/29-[DATE] related to cellulitis requiring intravenous antibiotic therapy and hydration.</p> <p>On interview [DATE] at 2:07 p.m., RN-B stated the DTI for R196 developed at the facility. RN-B stated R196 was sitting a lot and had no interest in doing anything. RN-B stated initially when R196 arrived at the facility she could have repositioned herself but R196 was not eating or drinking much and once the wound appeared she deteriorated rather quickly until a lift was needed to transfer her.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On interview [DATE] at 2:19 p.m., RN-A stated R196 was mobile when she was first admitted and could pivot transfer and walk a few steps and was working with physical therapy. RN-A indicated R196 liked to stay sitting in her chair and staff had a difficult time trying to get her to lay down in her bed. RN-A confirmed R196 did not have a wound on coccyx upon admission. RN-A stated interventions were started on [DATE] that included a nutritional supplement, repositioning program every 2-2.5 hours, wound care and treatments, air mattress ordered and Roho cushion to chair and wheelchair. RN-A stated a lot of the problem was lack of nutrition and pressure as R196 was not active. RN-A stated the first wound assessment was done [DATE] by an RN but red area was initially noted on [DATE] and was unsure when the wound was first reported to her or what the delay was for initial assessment. RN-A confirmed the next wound assessment wasn't completed until [DATE], 11 days later due to her absence. The wound was sacral/coccyx and when it opened it progressed up and outwards so became more sacral area.</p> <p>On interview [DATE] at 8:11 a.m., NP-D, wound specialist stated when she first saw R196 at the clinic, she had an infection and was sent to the hospital. NP-D stated unfortunately the wound was extensive and if further intervention had been started earlier, the severity of the wound could have been prevented. NP-D indicated she could not say if the wound was preventable or not but added the severity could have been prevented.</p> <p>On interview [DATE] at 8:54 a.m., RN-A stated I don't believe this was preventable and felt this was related to an end of life ulcer. RN-B stated she hadn't seen the wound from 5/23 until [DATE], so was not sure if signs of infection were present or not but stated the wound on [DATE] prior to going to the wound care clinic was very red.</p> <p>On interview [DATE] at 11:05 a.m., RN-C, also identified as MDS nurse, stated she completed the initial MDS assessment and toileting habits, nutrition, history of skin issues, activity level and diagnosis are taken into consideration when determining if resident is at risk for PU injury. The first Braden scale was completed by RN-D and R196 had a skin tear but her coccyx area was fine without redness. RN-C stated R196 was in therapy and was moving, getting up out of her chair. RN-C stated however R196's appetite wasn't good. RN-C stated initially R196 did not have risk factors for developing a pressure ulcer.</p> <p>On interview [DATE] at 10:56 a.m., LPN-A stated she was unsure if any preventative measures were put into place after discovery of the red area on the coccyx but if nothing was documented no further preventative care was completed at that time. LPN-A stated she does remember R196 was not repositioning herself at the time and was rarely moving.</p> <p>On interview [DATE] at 11:37 a.m., RN-A confirmed there were no interventions to prevent further skin breakdown between [DATE] when red area was discovered until [DATE] when she assessed the area and the wound was open. RN-A stated the facility does not do tissue tolerance tests but rather do a repositioning assessment. RN-A was not able to find a repositioning assessment completed on R196 throughout her stay at the facility.</p> <p>On interview [DATE] at 12:03 p.m., nursing assistant, (NA)-A stated he cared for R196 a lot and she rarely wanted to do anything including therapy. NA-A stated R196 started to give up, and refused to eat. NA-A stated they were repositioning R196 every 2 hours once the wound started. NA-A stated they had to start using the EZ-stand when around the time the wound started and by the time R196 went to the hospital she required use of a lift and 2 staff.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Mountain Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 745 Basinger Memorial Drive Mountain Lake, MN 56159	
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On interview [DATE] at 1:14 p.m., MD-C indicated he does not believe he saw R196's pressure ulcer at the facility when he saw R196 at the [DATE] visit. MD-C stated he would expect staff to have preventative cares and treatments in place especially for someone with a recent stroke like R196. MD-C was not able to determine if PU was preventable and stated the first mention of a PU in her medical record at the clinic was [DATE].</p> <p>On interview [DATE] at 1:23 p.m., MD-G indicated the wound and surrounding area was infected and wound was extensive when he first saw R196 on [DATE] at the Wound Care Clinic. MD-G stated it is difficult to say if wound was preventable, but as soon as evidence of stage I PU (redness) was identified interventions should have been put into place to prevent further damage.</p> <p>On interview [DATE] at 12:58 p.m., the director of nursing (DON) stated if a red area is noted on the skin would expect staff to put preventative measures in place upon discovery. The DON stated she would expect staff to completed measurements on an open wound every 3 days but at least every 7 days until healed. The DON stated she would like an RN to do them more often than weekly especially if the wound is worsening like R196's was.</p> <p>Facility Skin Assessment Pressure Ulcer Prevention and Documentation Requirements, dated [DATE] included:</p> <ol style="list-style-type: none"> 1. All residents will be identified for their risk of developing pressure ulcers on admission/readmission by a RN using the Braden Scale. Those residents determined to be at risk will have a Braden Scale completed weekly for the first four weeks following admission. 2. The RN will completed a Braden Scale on all residents quarterly or when the resident has a change in condition that could affect his or her risk of developing an ulcer. Residents who are unable to reposition themselves independently, as indicated on the Sit-Stand-Walk Data Collection Tool should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning scheduled is required for those residents unable to position themselves and is based on nutrition, hydration, incontinence, diagnosis mobility and observation of the resident's skin over a period of time. The Positioning Assessment and Evaluation is a required tool that is used to determine an individualized repositioning plan. 3. Notify the physician/practitioner of the ulcer and resident's condition to obtain orders for treatment. Inquire whether physician/practitioner believes it is clinically necessary to see resident. 4. The pressure ulcer should be assessed/evaluated at least weekly and documented the Wound RN Assessment tool. Daily Wound Data Collection is completed daily for Medicare residents. 5. If the pressure ulcer is not determined to be clinically unavoidable, the ulcer should show signs of improvement within two to four weeks. Signs of improvement might include decrease in size of wound, decrease in amount of exudate and improvement in tissue type. 6. If the resident's ulcer is clinically avoidable, not showing signs of healing and the interdisciplinary team and/or the physician have made modifications to the treatments and interventions, consider a referral to a wound care specialist and discussion with the location's medical director. 		