STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide dignity 2 of 3 residents (R5, R6) who were reviewed for dignity. Findings include:R5's face sheet dated 1/20/26, identified diagnoses of Alzheimer's, and dementia.R5's quarterly MDS dated [DATE], identified R5 had moderate cognitive impairment, no behaviors, used a walker and wheelchair; needed moderate assistance with dressing upper and lower body, independent to roll side to side, touching assistance to transfer locations.R5's care plan dated 10/27/25, identified self-care deficits. Interventions included R5 could not walk, used mechanical lift for transfers, and required 1-2 staff to assist with toileting needs.R5's progress note dated 1/2/26, identified hospice nurse visited and placed a urinary catheter.During an observation and interview on 1/20/26 at 8:23 a.m., R5 was in his recliner chair. R5's urinary catheter collection bag was hanging on a garbage can next to recliner without a dignity cover. Registered nurse (RN)-A was in room and stated urinecollection bags need to be covered, facility uses dignity bags. I don't like that it is on a trash can either. RN-A provided education to nursing assistant (NA)-A that urine collection bags cannot hang from garbage cans and a dignity bag must be provided to R5.During an observation and interview on 1/22/26 at 9:00 a.m., R5 was lying in bed. catheter bag was on floor in wash basin with no dignity cover. Licensed practical nurse (LPN)-B stated R5 was supposed to have a cover on his catheter bag. LPN-B went to R5's closet, pulled out a dignity bag, applied to R5's urine collection bag.During an interview on 1/20/26 at 1:18 p.m., NA-A stated urine collection bags should be covered for dignity, same thing for hanging them on trash cans, if someone would walk by they could see the urine in the bag.During an interview on 1/20/26 at 10:44 a.m., clinical care lead registered nurse (CCLRN)-A stated urine collection bags should be covered for dignity and should not hang off garbage cans, there is a pocket on the other side of the recliner where it could have gone.R6R6's face sheet dated 1/20/26, identified diagnoses of anxiety disorder.R6's care plan dated 1/12/26, identified self-care deficits that required two staff for bed mobility.During an observation on 1/20/26 at 8:05 a.m., NA-B exited R6's without shutting the door and the privacy curtain drawn leaving R6 sitting on the edge of the bed with a brief on, secured around waist, and her pants pulled down to her knees while NA-C and NA-G provided support to keep R6 in the seated position. R6 was yelling help! During an interview on 1/20/26 at 10:34 a.m., NA-C and NA-G stated R6's door should have been shut when she was sitting on the edge of her bed in a brief and pants at her knees.During an interview on 1/22/26 at 12:14 p.m., director of nursing (DON) stated she expected the door to be shut during cares. Sometimes, the door does not shut unless slammed and was unsure if the NA's would have been able to get the curtain shut when performing cares on R6. DON expected covers on catheter bags. The facility purchased a bunch recently. DON was not sure if staff thought they were disposable, but they should not be thrown out unless ripped.The facility policy Resident Dignity revised 12/18/25, identified the IDT will assist all staff members in maintaining the dignity of (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review the facility failed to notify the physician and resident representative regarding changes to skin integrity and treatment orders for 1 of 3 residents (R1) reviewed for change in condition. Findings include:R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body).R1's care plan dated 11/20/25, identified R1 had shearing on his left and right buttock and is at risk for skin breakdown and shearing related to immobilization/chairbound/bedbound and used the total lift sling evidenced by open shearing areas on both left and right buttock. Interventions included to keep skin clean and dry. Use skin barrier cream to buttocks daily and protect these areas with a dressing when open and draining. High risk for skin injury-use caution during transfers when using the sling being cautious to not quickly and forcefully place the sling under R1. Monitor for signs of shearing. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to health care provider.R1's faxed request to physician dated 11/21/25, identified FYI: R1 continued to have some shearing on buttocks off and on due to resident not wearing a brief as this causes other issues with skin breakdown in groin and penial area. Will continue to apply skin barrier cream to bottom when appropriate or cover with a coccyx mepilex if area is more open and drainage. Physician responded OK.R1's faxed request to physician dated 11/25/25, identified R1 was more depressed and refused to get out of bed which caused increased skin breakdown and open sores on his buttocks. Physician response was to get a psych consult. There was no indication R1's care plan was revised that addressed R1's refusals or repositioning program.R1's Wound Data Collections between 12/12/25 and 12/26/25 identified the area of impaired skin integrity was on R1's coccyx and/or coccyx/sacrum and not buttocks as described in the Skin Observations. Wound Data collections during this period were not comprehensive as none of these assessments included measurements nor included type of wound present. Examples from the record included: R1's Wound Data Collection dated 12/12/25, identified coccyx. Dressing present and intact. No drainage on the dressing. R1's Wound Data Collection dated 12/16/25, identified wound location coccyx and the site was sacrum. Protective cream applied after shower. Dressing present and intact. No drainage on dressing.R1's physician note dated 12/19/25, had no mention of shearing injury.R1's nursing order dated 12/25/25-12/30/25, identified clean buttock area with soap and water or wet wipes. Apply a thin layer of zinc oxide to both buttock areas and cover each buttock with an ABD pad and secure the outer edge with tape daily.R1's Wound Data Collection dated 12/30/25, identified left buttock has shearing to area, right buttock has darkened area with redness surrounding it. Applied skin prep and covered with mepilex.R1's Skin Observation dated 12/31/25, identified right buttock shearing, left buttock shearing-black and blue tissue noted, left lateral foot-dried calloused area. Covered with ABD pads and secured with tape. Applied iodine to left lateral foot.In review of R1's records between 12/5/25 through 12/31/25, it was not evident the physician was notified of new wounds nor changes to treatment orders. Additionally, between 12/27/25 through 12/31/25 there was no indication R1's right and left buttock wounds and left lateral heel were comprehensively assessed. During a phone interview on 1/20/26 at 1:47 p.m. family member (FM)-A [emergency contact] stated the facility had yet to tell her that R1 had a wound on his buttocks. FM-A found out about the wound after a text message was sent from R1's visitor, who discovered the severity of the wound, while assisting R1 with cares a week prior.During a phone interview on 1/20/26 at 1:41 p.m., certified wound nurse practitioner (CWNP)-A stated she knew R1 well and had followed his wound care from 8/19/25-11/7/25, when all wounds were healed. Wound clinic received a referral on 1/12/26 for pressure ulcer right lateral foot, left and right buttock pressure ulcers from facility. On (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/13/25, R1 came to the wound clinic.During an interview on 1/22/26 at 12:14 p.m. director of nursing (DON) stated the facility received a call from the clinic that FM-A was upset about R1's wound and that she had not been notified of the wounds. FM-A had found out about the wounds from R1's girlfriend. Facility records did not have FM-A listed as emergency contact. Nurses should notify physician with any changes of resident condition.The facility Notification of Change policy revise 12/12/25, identified the facility must immediately inform the resident, consult with physician and notify resident representative 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to update the care plan for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include:R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body), pressure ulcer of right heel (diagnosis added 8/11/25), type 2 diabetes, and obesity. On 1/13/26, diagnoses of pressure ulcer of other site, pressure ulcer of unspecified, pressure ulcer of left buttock were included.R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had no cognitive impairments, no rejection of care, had an indwelling catheter and ostomy, had impairment on both sides of lower extremities, dependent for lower body care, maximum assistance to roll left and right, and dependent to transfer from surfaces. R1 was at risk of developing pressure ulcers/injuries but did not have any pressure ulcers and no open lesions. Treatments included pressure-reducing devices for chair and bed. R1 was not on a turning and reposition program, no nutrition or hydration interventions, and no dressing or treatments to feet.R1's Nursing Admit/Re-admit Data Collection dated 7/24/25, identified R1 had a right heel wound. Despite the instructions on the form that directed .staging to be completed by an RN [registered nurse].Important Note: include the type of skin observation (blanchable or non-blanchable), size, color, odor or discharge in the description., there was no further information documented. R1's care plan dated 7/25/25, did not identify a skin integrity focus nor identified R1 had a wound on his right heel. The care plan identified R1 required extensive assistance of one staff to turn from side to side. R1 was able to assist by using the grab bars located on both sides of the bed. Dependent on two staff to transfer between surfaces using the mechanical lift.R1's care plan dated 8/4/25, identified R1 had potential for pressure ulcer development related to dehydration, disease process, history of ulcers, and immobility. Interventions directed staff to avoid positioning on oxygen and indwelling urinary catheter tubing; Provide pressure redistributing mattress on bed and cushion on manual wheelchair; and Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care.R1's RN Wound assessment dated [DATE], identified right heel unstageable pressure ulcer. The wound assessment did not address the red sacrum identified on the 8/11/25 assessment and there was no indication the care plan was updated to reflect the off-loading boots until 10/30/25. (however, updated on TAR 8/11/25).R1's progress note dated 9/4/25, identified R1 had a new pressure sore to his right buttock. R1 had been refusing staff to get up in his chair at mealtimes per therapy. Explained the risks of not repositioning but R1 continued to refuse.R1's Wound Clinic Visit Report dated 9/10/25, identified the stage 3 pressure ulcer to right heel. R1 had new concerns of an ulceration to the urinary meatus (opening of the urethra) from his catheter. R1 reported he had reconstructive surgery to the area and had chronic issues with erosion (loss of epithelial tissue) of the glans (tip of penis) as a result of long-term catheter use. This wound was classified as stage 3 pressure ulcer at 3 o'clock. Noted R1's incontinent brief was causing serious tension to the catheter that led to the breakdown. Repositioned the device that holds the catheter in place at the leg to the right leg. Brief removed in order to avoid further irritation to the skin and silicon barrier cream twice daily. In review of R1's record there was no indication the care plan was revised to identify the presence of the new ulcer on the urinary meatus nor revised to address interventions pertaining to the urinary catheter placement and incontinent garment usage.R1's care plan dated 10/30/25, was revised to include use of heel boots/protective boots while in bed and received diabetic nutritional supplements twice daily for wound healing. The care plan did not address the wound clinic's directions for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevention/minimization of re-current pressure injuries pertaining to the urinary catheter nor address interventions to prevention/minimization the risk of re-current shearing injuries to buttocks until 11/20/25.During an interview on 1/22/26 at 12:14 p.m., director of nursing (DON) stated she expected the care plan to be followed and RN nurse leaders to update the care plan quarterly and with changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to identify, comprehensively assess, monitor, and develop interventions to prevent/mitigate the risk of pressure ulcer development and/or deterioration for 4 of 4 residents (R1, R2, R3, R5). The facility's failure resulted in Immediate Jeopardy (IJ) for R1 when the facility failed to prevent and manage impaired skin integrity that progressed to bone and soft tissue infections which required hospitalization for treatment and management.The IJ began on 12/31/25 after R1's existing buttock wound(s) were documented as black and blue tissue to the buttocks, with ongoing inconsistent identification of skin integrity and without completion of comprehensive wound assessments, physician notification, or implementation of effective treatment and pressure-relieving interventions to prevent further deterioration. The Administrator, director of nursing (DON), regional clinical services director, senior director, and clinical care lead registered nurse (CCLRN)-B were notified of the IJ on 1/22/26 at 1:34 p.m. The IJ was removed on 1/27/26 at 1:58 p.m., but non-compliance remained at the lower scope and severity level E, which indicated no actual harm, with the potential for more than minimal harm that is not immediate jeopardy. R1R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body), pressure ulcer of right heel (diagnosis added 8/11/25), type 2 diabetes, and obesity. On 1/13/26, diagnoses of pressure ulcer of other site, pressure ulcer of unspecified, pressure ulcer of left buttock were included.R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had no cognitive impairments, no rejection of care, had an indwelling catheter and ostomy, had impairment on both sides of lower extremities, dependent for lower body care, maximum assistance to roll left and right, and dependent to transfer from surfaces. R1 was at risk of developing pressure ulcers/injuries but did not have any pressure ulcers and no open lesions. Treatments included pressure-reducing devices for chair and bed. R1 was not on a turning and reposition program, no nutrition or hydration interventions, and no dressing or treatments to feet.R1's Nursing Admit/Re-admit Data Collection dated 7/24/25, identified R1 had a right heel wound. Despite the instructions on the form that directed .staging to be completed by an RN [registered nurse].Important Note: include the type of skin observation (blanchable or non-blanchable), size, color, odor or discharge in the description., there was no further information documented. R1's care plan dated 7/25/25, did not identify a skin integrity focus nor identified R1 had a wound on his right heel. The care plan identified R1 required extensive assistance of one staff to turn from side to side. R1 was able to assist by using the grab bars located on both sides of the bed. Dependent on two staff to transfer between surfaces using the mechanical lift.R1's Skin Observation dated 7/31/25, identified R1 had a bath and skin check was completed. The evaluation had no mention of the right heel wound as identified on 7/24/25.In review of R1's record between 7/24/25 through 8/3/25, the care plan was not revised to identify the heel wound and not revised until 8/4/25 with new pressure relieving interventions to prevent deterioration and new wound development. R1's progress note dated 8/1/25, identified R1 was transferred to the hospital. R1's care plan dated 8/4/25, identified R1 had potential for pressure ulcer development related to dehydration, disease process, history of ulcers, and immobility. Interventions directed staff to position oxygen and indwelling urinary catheter tubing appropriately; Provide pressure redistributing mattress on bed and cushion on manual wheelchair; and notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care.R1's progress note dated 8/11/25, identified R1 returned from hospital. R1's Nursing Admit/Re-admit Data Collection dated 8/11/25, had the same instructions for documenting the wound as previous assessment dated [DATE]. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	assessment identified R1 had right heel wound with a description of dried blood area size of nickel, and sacrum slightly red. These areas were not measured, staged, or the surrounding skin condition identified. Despite the identification of new impaired skin integrity on R1's sacrum and the existing heel wound, there was no indication R1's care plan was revised with new pressure relieving/prevention interventions to address R1's sacral redness.R1's Treatment Administration Record (TAR) dated 8/11/25, identified for the nurse to acknowledge every shift: heel lift boots while in bed for heel protection and pressure reduction. Assess bony prominences, turn and reposition every 2 hours, protect skin and keep clean and dry, moisture barrier for incontinence, use lift pad.R1's RN Wound assessment dated [DATE], identified right heel unstageable pressure ulcer. There is a 1.5-centimeter (cm) x 1.5 cm eschar (dry, dark scab) wound that was present on readmission. Surrounding skin is slightly pink. Mepilex applied to wound and off-loading boots to both feet. Referral made to local wound center. The wound assessment did not address the red sacrum identified on the 8/11/25 assessment and there was no indication the care plan was updated to reflect the off-loading boots until 10/30/25 (however updated on TAR 8/11/25).R1's Wound Clinic Visit Report dated 8/19/25, identified the wound on R1's right heel as stage 3 pressure ulcer. Wound measured 1.0 cm x 1.2 cm x 0.2 cm depth. No tunneling or undermining (pocket or shelf beneath skin) noted. Small amount of serosanguineous drainage noted. Wound margin is distinct with the outline attached to wound base. No granulation (new tissue growth) within the wound bed. A large amount (67-100%) of necrotic tissue within the wound bed including eschar and adherent slough. No probe to bone. The wound was debrided (removal of dead, infected, or damaged tissue) of eschar tissue and was not tolerated well. New wound measurements were 1.0 cm x 1.2 cm x 0.3 cm depth. Treatment included cleanse with normal saline, apply Iodosorb ointment to wound bed, avoid getting on surrounding skin. Cover with gauze sponge and tape. Prevalon boot at ALL times. Other non-wound condition instructions included buttocks looks okay, no need for Mepilex unless there is a concern, than may apply. In review of R1's record, despite the direction for R1 to have Prevalon boot (brand of off-loading boot) there was no indication the care plan was revised until 10/30/25 (however was on the TAR 8/11/26).Review of R1's wound clinic notes in conjunction with RN Wound Assessments and Skin Observations between 8/20/25 through 9/3/25, did not identify any impaired skin integrity to R1's buttocks/sacral/coccyx regions and or perineal areas.R1's progress note dated 9/4/25, identified R1 had a new pressure sore to his right buttock. R1 had been refusing staff to get up in his chair at mealtimes per therapy. Explained the risks of not repositioning but R1 continued to refuse. Faxed physician regarding new pressure sore found on R1's right buttock. R1's record did not include a comprehensive assessment of R1's pressure ulcer to right buttock.R1's Wound Clinic Visit Report dated 9/10/25, identified the stage 3 pressure ulcer to right heel. Measured 0.8 cm x 0.4 cm x 0.2 cm depth. New orders for Santyl ointment in wound bed. R1 had new concerns of an ulceration to the urinary meatus (opening of the urethra) from his catheter. R1 reported he had reconstructive surgery to the area and had chronic issues with erosion (loss of epithelial tissue) of the glans (tip of penis) as a result of long-term catheter use. This wound was classified as stage 3 pressure ulcer at 3 o'clock. Measured 1.5 cm x 0.7 cm x 0.1 cm depth. Medium amount of serous (watery discharge) noted. Wound margin is flat and intact. No granulation within the wound bed and small amount of necrotic tissue within the wound bed. Noted R1's incontinent brief was causing serious tension to the catheter that led to the breakdown. Repositioned the device that holds the catheter in place at the leg to the right leg. Brief removed in order to avoid further irritation to the skin and silicon barrier cream twice daily. In review of R1's record there was no indication the care plan was revised to identify the presence of the new ulcer on the urinary meatus nor revised to address (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	interventions pertaining to the urinary catheter placement and incontinent garment usage.R1's Skin Observation dated 9/12/25, indicated new wound development; left buttock-open area with current treatment of a Mepilex to area and right buttock open area with current treatment as barrier cream to area. In review of R1's record there was no indication these areas were comprehensively assessed nor evident a comprehensive assessment was completed for a turning and repositioning program, nor the care plan was revised with pressure relieving/prevention measures.R1's wound clinic notes, RN Wound Assessments and Skin Observations records were reviewed between 9/10/25 through 11/7/25. The Wound Clinic notes during this period identified on 9/10/25 a new wound on R1's urinary meatus stage 3 pressure ulcer which was comprehensively assessed and was documented as healed on 9/25/25; associated interventions for this wound included avoidance of briefs and use of undergarment pads only, which was recommended on 9/18/25 and reiterated on 10/2/25, at which time R1 was documented as wearing a brief despite prior recommendations. The left and right buttock skin impairments identified on Skin Observation form on 9/12/25 were not addressed by the wound clinic until 10/17/25, when the wound clinic determined the presence of partial thickness shearing injury; the shearing injury was subsequently documented as healed on 10/24/25. The right heel pressure ulcer was comprehensively assessed by the wound clinic beginning 9/18/25, with ongoing monitoring and treatment recommendations including strict offloading, and was documented as healed on 11/7/25. In contrast, the facility's RN Wound Assessments, progress notes, and Skin Observations did not include ongoing comprehensive assessments of R1's buttock wounds identified on 9/4/25 and 9/12/25 nor identify the urinary meatus pressure ulcer prior to wound clinic identification on 9/10/25 and reflected inconsistent wound identification with variable assessment details.R1's quarterly Braden Scale for Predicting Pressure Score Risk dated 10/30/25, identified R1 was at moderate risk for pressure ulcers. The assessment included an intervention guide, for moderate risk which suggested interventions of: frequent turning with a planned schedule, use foam wedges for thirty degree lateral positioning, pressure reduction support surfaces, maximal remobilization, protect heels, manage moisture, manage nutrition, manage friction and shear*if other major risk factors present, advance to next level of risk. Also included were interventions to manage moisture, nutrition, friction and shear, and other general care issues.R1's care plan dated 10/30/25, was revised to include use of heel boots/protective boots while in bed and received diabetic nutritional supplements twice daily for wound healing. The care plan did not address the wound clinic's directions for prevention/minimization of re-current pressure injuries pertaining to the urinary catheter nor address interventions to prevention/minimization the risk of re-current shearing injuries to buttocks until 11/20/25.R1's Wound Clinic Visit Report dated 11/7/25, identified R1 was discharged from wound center today.R1's Skin Observation dated 11/11/25, identified no skin conditions observed.R1's interdisciplinary team (IDT) progress note dated 11/12/25, identified IDT met to review resident status. Followed by outside wound care services (sic-discharged on 11/7/25). R1 is to be up in chair for about two hours around mealtimes, compliant, often refuses. Diabetic boost taken for wound healing. New wounds seen on bottom and back, he can reposition himself but does not, a lot of the time. Monitoring these wounds. He needs much re-education on why these two new wounds are not healing (lack of repositioning, not getting out of bed.) mepilex on. these wounds are worsening. Using skin barrier to these areas. It is felt the buttock wound is due to the shearing, not pressure. He also has a wound on the penis where the catheter comes out. Silicone cream being used and ABD pads.In review of R1's IDT progress notes from 9/30/25-1/14/26, the information and word structure remained almost identical. According to the Wound Clinic notes R1's buttock wounds were healed on 10/24/25 and based on the R1's skin records after 10/25/24 that identified coccyx wound/buttock skin (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	impairment it could not be ascertained if the IDT notes were redundant since 9/30/25 or the wounds on and after 11/12/25 were new wounds. R1's IDT progress note dated 11/18/25, was verbatim from progress note on 11/12/25 with no new information identified. R1's progress note dated 11/18/25, identified R1 would not get out of bed this shift, nor would he take a bath.R1's Skin Observation dated 11/20/25, identified shearing on left and right buttocks. No comprehensive assessment and/or additional information was included. R1's care plan dated 11/20/25, identified R1 had shearing on his left and right buttock and is at risk for skin breakdown and shearing related to immobilization/chairbound/bedbound and used the total lift sling evidenced by open shearing areas on both left and right buttock. Interventions included to keep skin clean and dry. Use skin barrier cream to buttocks daily and protect these areas with a dressing when open and draining. High risk for skin injury-use caution during transfers when using the sling being cautious to not quickly and forcefully place the sling under R1. Monitor for signs of shearing. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to health care provider.R1's faxed request to physician dated 11/21/25, identified FYI: R1 continued to have some shearing on buttocks off and on due to resident not wearing a brief as this causes other issues with skin breakdown in groin and penial area. Will continue to apply skin barrier cream to bottom when appropriate or cover with a coccyx mepilex if area is more open and drainage. Physician responded OK.R1's faxed request to physician dated 11/25/25, identified R1 was more depressed and refused to get out of bed which caused increased skin breakdown and open sores on his buttocks. Physician response was to get a psych consult. There was no indication R1's care plan was revised that addressed R1's refusals or repositioning program.R1's IDT progress note dated 11/26/25, was verbatim when compared to IDT progress notes dated 11/12/25 and 11/18/25 which included R1 is to be up in chair for about two hours around mealtimes, compliant, often refusesDuring an interview on 1/22/26 at 8:51 a.m., NA-D stated a resident could refuse cares three times before they told the nurse. NA-D had worked with R1 since admission and R1 rarely refused cares. When R1 refused care, NA-D would go back later and R1 would always accept the cares offered.R1's record was reviewed which included Skin Observations, Wound Data Collections, and progress notes between 11/8/25 through 12/30/26. The skin observations identified inconsistent identification of the presence and location of wound (coccyx vs right and/or left buttocks) with no comprehensive assessment of the impaired skin integrity when identified. Skin Observation dated 12/5/25 identified pressure sore to coccyx, Observation on 12/12/26 identified no skin impairments, Observations dated 12/19/25, 12/29/25, and 12/30/25 described wound(s) on buttocks as shearing.R1's Wound Data Collections between 12/12/25 and 12/26/25 identified the area of impaired skin integrity was on R1's coccyx and/or coccyx/sacrum but not buttocks as described in the Skin Observations. Wound Data collections during this period were not comprehensive as none of these assessments included measurements nor included type of wound present. Examples from the record included:R1's Wound Data Collection dated 12/12/25, identified coccyx. Dressing present and intact. No drainage on the dressing.R1's Wound Data Collection dated 12/16/25, identified wound location coccyx and the site was sacrum. Protective cream applied after shower. Dressing present and intact. No drainage on dressing. R1's physician note dated 12/19/25, had no mention of shearing injury or other wounds.R1's IDT progress note dated 12/24/25, was verbatim compared to IDT progress notes dated 11/12/25 and 11/18/25, and 11/26/25 with no new information added. R1's nursing order dated 12/25/25-12/30/25, identified clean buttock area with soap and water or wet wipes. Apply a thin layer of zinc oxide to both buttock areas and cover each buttock with an ABD pad and secure the outer edge with tape daily.R1's Wound Data Collection dated 12/27/25, identified coccyx. Dressing present and intact. No drainage on dressing. Pink skin around dressing. Cleansed with (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	wound cleanser, applied ABD pad, secured with tape.R1's Wound Data Collection dated 12/29/25, identified a new wound on R1's left lateral foot that measured 1.2 cm x 1.0 cm x 0.1 cm depth. [NAME] in color. Applied skin prep and covered with Mepilex. No other information was included.R1's Skin Observation dated 12/29/25, identified left and right buttock shearing. Cleansed area and covered with ABD pads secured with tape. Applied zinc oxide to reddened areas that were not open.R1's Skin Observation dated 12/30/25, right and left buttock shearing. Mepilex and ABD to areas.R1's Wound Data Collection dated 12/30/25, identified left buttock has shearing to area, right buttock has darkened area with redness surrounding it. Applied skin prep and covered with mepilex.R1's Skin Observation dated 12/31/25, identified right buttock shearing, left buttock shearing-black and blue tissue noted, left lateral foot-dried calloused area. Covered with ABD pads and secured with tape. Applied iodine to left lateral foot. In review of R1's records between 12/5/25 through 12/31/25, it was not evident the physician was notified of new wounds nor changes to treatment orders. Additionally, between 12/27/25 through 12/31/25 there was no indication R1's right and left buttock wounds and left lateral heel were comprehensively assessed. Nursing order dated 12/31/25-1/8/26 directed clean buttock area with soap and water or wet wipes. Cover each buttock with ABD pad and secure outer edges with tape. Apply zinc oxide to other areas that are red but not open daily. Skin Observations dated 1/2/26, 1/3/26, and 1/6/26 reflected variable identification of skin integrity. On 1/2/26, no skin conditions were observed. On 1/3/26, a small dark pressure area measuring 1.0 cm x 1.0 cm was identified on the left heel/lateral area, and skin prep and Mepilex were applied. On 1/6/26, no additional skin concerns were identified, and documentation noted ongoing daily treatment to the buttocks.During an interview on 1/20/26 at 2:40 p.m. with NA-C and NA-B present, nursing assistant (NA)-C stated R1 had the wounds on his buttocks prior to September. The buttocks had gotten progressively worse from the size of a nickel to the size of a quarter. NA-C was unable to articulate a time frame, for when the buttocks looked worse, but it was somewhere from two weeks to a month and a half ago. NA-B stated R1 refused to turn and reposition however, if staff re-approached when he refused to get out of bed that seemed to work. R1 would sometimes pull the wedge cushion out that helped him stay on his side when in bed. If R1 went to his recliner or wheelchair he would want to go back to bed after about 20 minutes.R1's Wound Data Collection dated 1/7/26, initial data collection for left buttock wound, type of wound was not included. The wound measured 8.0 cm x 6.0 cm x 0.2 cm depth. Drainage present with a presence of possible complications described as eschar and slough present. Wound bed was 25% slough and 75% eschar. Minimum sanguineous drainage with no odor present. Wound edges were macerated and erythematous. Cleansed area with soap and water, covered with hydrofera blue, ABD pads secured with tape.R1's Wound Data Collection dated 1/7/26, initial data collection for right buttock wound, type of wound was not included. The wound measured 6.0 cm x 4.0 cm x 0.2 cm depth. Drainage present with a presence of possible complications described as eschar and slough present. Wound bed was 60% slough and 35% eschar. Moderate sanguineous drainage with no odor present. Wound margins were macerated and erythematous. Cleansed area with soap and water, covered with hydrofera blue, ABD pads secured with tape.R1's progress note dated 1/7/26 at 9:30 p.m., identified R1 stated he was not feeling like himself. Stated he was having chest/heart pain but mostly felt his heart hurt. Nitro administered and pain was 8/10 to begin and 2/10 after nitro given.R1's progress note dated 1/8/26 at 10:12 a.m., identified physician was notified for R1 having heart hurting and pain going down back on left side. Had good results from nitro the evening before. Verbal order to go to emergency department. At 12:55 p.m., returned from emergency room with no changes made to medications after electrocardiogram and x-ray obtained.During an interview on 1/20/26 at 2:46 p.m., RN-B stated she last worked with R1 on 1/7/26 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and 1/8/26. When she changed the dressing on 1/8/26, there was not an odor to the wound, but had felt there had been an odor prior. The wound was red, moist, and the skin around was pink. There was an additional small wound just below the one that was the original pressure ulcer on the left side. RN-B informed clinical care lead RN (CCLRN)-B the left buttock was worse, it had spread and was bleeding; the right buttock was only reddened skin. RN-B did not work again until after R1 had been sent to the wound clinic on 1/13/26. On 1/21/26 at 10:09 a.m., RN-B stated CCLRN-B would always measure the wounds, sometimes do the wound care, notify the physician, and put the orders in the computer. Nurses would follow what the computer directed for orders. CCLRN-B was always the first person RN-B would go to with wound concerns as she was a wound care nurse prior to working at the facility. RN-B reviewed documentation on R1's skin for December and January and noted the wounds had not been measured until 1/7/26.R1's progress note dated 1/12/26 at 6:06 p.m., identified R1 complained of nausea. At 10:55 p.m., nausea was better but now complaints of headache. Medicated with as needed Tylenol. Has two appointments in the morning.R1's progress note dated 1/13/26 at 1:08 p.m., identified wound clinic called and stated they sent R1 to the emergency department with fever, chills, and R1 would most likely be admitted .During a phone interview on 1/20/26 at 1:41 p.m., certified wound nurse practitioner (CWNP)-A stated she knew R1 well and had followed his wound care from 8/19/25-11/7/25, when all wounds were healed. Wound clinic received a referral on 1/12/26 for pressure ulcer right lateral foot, left and right buttock pressure ulcers from facility. On 1/13/25, R1 came to the wound clinic. The wounds were classified as unstageable on right lateral foot, unstageable pressure ulcer to the gluteus, and stage 3 left ischium. The gluteus was very advanced and infected, so wound clinic sent R1 to the emergency department. CWNP-A saw R1 inpatient at the hospital from [DATE]-[DATE] and debrided the wound daily. The wound was to the bone when CWNP-A last saw it on 1/17/26. R1 was diagnosed with osteomyelitis, cellulitis, and soft tissue infection. Emergency department was suspicious of one but unable to officially diagnose until after MRI and MRI showed it went to the bone. R1 could die from these infections.R1's care plan was revised on 1/16/26 after R1 was admitted to the hospital on [DATE]. The care plan identified R1 often refused repositioning and refused to get out of bed. Interventions included to educate R1/family of the possible outcomes of not complying with repositioning. Attempt non-pharmacological interventions including re-approach and report to nurse if refused a second time.During an interview on 1/22/26 at 10:42 am LPN-A stated R1 moved in bed with staff help. R1 was able to help by turning a little bit on his top half but he needed assistance of two people to get him on his side and staff performed most of the work. R1 was not on a turning and repositioning schedule, and staff would do cares in the morning and evening. Staff encouraged R1 to move to his recliner for meals but he would refuse a lot. Nurses were to chart when he refused.R1's hospital History and Physical records dated 1/17/26, indicated R1 was admitted to the hospital on [DATE] for a sacral decubitus ulcer and osteomyelitis of pelvis. MRI of pelvis with and without contrast was completed and showed osteomyelitis of the proximal coccygeal segment (bone infection near the tailbone) with likely anteriorly dislocated middle coccygeal segment (section tail bone shifted forward-can happen with long standing pressure, infection, or tissue breakdown in the area). Cellulitis within right pelvic sidewall and right medial buttocks (infection in nearby soft tissues of the pelvis and buttock area). R1 reported his girlfriend noticed the wound on approximately 1/10/26 and according to documentation facility had noted a sacral wound for approximately two weeks. R1 reported a couple of wounds to his heels which he had previously received treatment. There is a 2.5 cm x 2.5 cm lesion on lateral aspect of right foot with no significant erythema or discharge. Records indicated on 1/20/26 R1 remained in the hospital for ongoing treatment. During a phone interview on 1/20/26 at 1:47 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	p.m. family member (FM)-A stated the facility had yet to tell her that R1 had a wound on his buttocks. FM-A found out about the wound after a text message was sent from R1's visitor, who discovered the severity of the wound, while assisting R1 with cares a week prior to R1 being sent to the wound clinic. R1 remained in the hospital with cellulitis and osteomyelitis, he had debridement's, a wound vacuum to his buttock, possible sepsis and kidney failure. R1 could die it is an avoidable wound they didn't tend to.During a follow-up interview on 1/22/26 at 10:05 a.m., CCLRN-B stated shearing was not a form of pressure. Interventions for R1 were in the care plan, but R1 refused to get out of bed. He was supposed to be up for meals. R1 could reposition himself and turn himself side to side in bed. R1 had a pressure-relieving mattress but if he wanted something that had more pressure relief, like an air mattress, it was up to R1 to contact the social worker or his case manager. Staff would reposition R1 to the wheelchair or recliner and that would distribute pressure in a different area. CCLRN-B had instructed R1 to move and get off his bottom various times. Pressure would be distributed to a different area if he got up in his wheelchair or recliner (did not articulate how long R1 could sit) and did not stay in his bed. R1 did go to a psychiatrist appointment in December 2025, but no interventions or suggestions for the care plan to help R1 with not refusing cares were discussed. R1's bottom was black and blue, always looked discolored and darker, and then it would heal. That was always something that was monitored. If skin was breaking down, a Mepilex would be appropriate but the facility did not have a large enough Mepilex, possibly related to payor concerns, so an ABD pad was used. Sometimes the mepilex and/or ABD were used just to protect the skin on his bottom. Nursing staff would always look for signs and symptoms of infection but CCLRN-B was unable to find documentation to that effect. CCLRN-B stated it would depend on the injury or what it looked like, she would monitor for a day or two, add orders in the medical record based off her experience from working at the wound clinic for three years. Typically, would communicate with physician when a wound changed and most of the time the physician would give a referral for the wound clinic. CCLRN-B acknowledged cleansing the buttock wounds with soap and water or wet wipes was not a standing order, but was unable to articulate the clinical rationale, physician authorization, or evidence-based standard supporting this practice. CCLRN-B stated she began the treatment of using hydrofera blue on R1's buttocks prior to getting orders from a physician.R1's hospital After Visit Summary dated 1/23/26, identified new orders for Intravenous medications ceftriaxone 50 milliliters every 24 hours, and daptomycin 600 milligrams for bone and joint infection; metronidazole 500 milligrams three times a day by mouth for osteomyelitis.During an observation and interview on 1/23/26 at 2:41 p.m., R1 returned to the facility from hospital around noon. R1 stated the facility had not provided education prior to hospitalization on the risks of not repositioning. They about killed me; I have never been that sick. R1 would like an air mattress on the bed but the facility told R1 an air mattress would make the wounds worse. R1 was positioned on his back in bed, and two wedge cushions were lying in the recliner. R1 had heel boots on bilateral heels and stated there was a wedge under his back. R1 stated he was supposed to be turned every two hours, and it had been past two hours. R1 would turn on his side if the staff came and helped him. R1 did not say if he ever refused position changes.During an observation on 1/26/26 at 9:02 a.m., R1 was sitting in a recliner in his room. Heel boots in place and air mattress on bed.During an interview on 1/26/26 at 10:15 a.m., RN-B could not find orders in R1's medical record to change R1's dressings, even though R1 returned to the facility on 1/23/26. RN-B alerted DON, RN-D, and DON-B. During an interview on 1/26/26 at 10:43 a.m., R1 was in bed, laying on his back. R1 stated staff had not done anything with his heels all weekend. Staff put the air mattress on his bed on 1/25/26 and staff would only put the wedges in if he told them too.During an observation and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	interview on 1/26/26 at 10:58 a.m., CCLRN-B and DON-B went to R1's room to complete dressing changes. CCLRN-B stated the left lateral foot wound had been a blister prior to hospitalization, was pretty much healed, looks really good, slightly open and was not a pressure ulcer, but a diabetic wound. DON-B identified the area as partial thickness, barely open, pink, healthy tissue, slightly pink around wound with some edema, raised but that could be the bone that was raised. CCLRN-B painted the entire wound and surrounding tissue with betadine and stated the wound was not open on 1/23/26 when assessed. CCLRN-B stated the left heel was blanchable, normal pink colored skin. DON-B advised CCLRN-B to follow the current wound treatment order and update the physician on progress. Toenails on left foot were observed pressing into adjacent toes, creating indentations in the skin. Upon inquiry, CCLRN-B stated she was unaware of these skin conditions until identified during the observation. Gauze was placed between the toes to relieve pressure and CCLRN-B stated she would trim the toenails later. CCLRN-B stated prior to hospitalization the area on the right lateral side of the foot was a blister. DON-B stated the area was large, circular and dark colored inside and questioned if it was an unstageable pressure ulcer. DON-B stated it should be labeled as unstageable so the floor nurses would keep a better eye on it. DON-B did not see any blanching and that would be the other red flag for the area. CCLRN-B stated that was the weird thing, he got both of the blisters while wearing his heel boots. Measured the darkened area at 1.5 cm x 2.5 cm and noted a small open area at the top of the blister that measured 0.3 cm x 0.2 cm x 0.1 cm depth. CCLRN-B observed the right heel and stated it was blanchable, pink in color, and appeared healed. DON-B observed the right heel and stated it should be staged as a suspected deep tissue injury as it was slightly blue in color and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to assist 1 of 3 residents (R1) who requested to be seen by the dentist. Findings include:R1's face sheet dated 1/20/26, identified diagnoses of paraplegia (paralysis of legs and lower body), type 2 diabetes,R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had no cognitive impairments, no rejection of care, and no obvious or likely cavities or broken natural teeth.R1's Nursing Admit/Re-admit Data collection dated 8/11/25, identified R1 had no dentures or bridges, no natural teeth or tooth fragments, obvious or likely cavity or broken natural teeth. Additional comments identified R1 would like to pursue some dental care.During an interview on 1/23/26 at 2:41 p.m., R1 stated no one at the facility ever worked with him to make a dental appointment. R1 stated he had told clinical care leader registered nurse (CCLRN)-B at some point.During an interview on 1/20/26 at 11:52 a.m., CCLRN-B stated she had completed R1's Nursing Admit/Re-admit Data. CCLRN-B stated county case workers manages R1 and it would be them or director of nursing (DON) that would have to approve a dental appointment, It's not like they can just go in town here, it is a process CCLRN-B could not articulate the process for a resident to get a dentist appointment if they requested. CCLRN-B was not sure who started the process to get R1 a dental appointment as he requested. CCLRN-B reviewed R1's record and was unable to find documentation that would identify any attempts to set up a dental visit. The facility Dental and Oral Care, Dental Health Assessment, Dental Services policy reviewed 4/6/25, identified the location provides or obtains from an outside source routine and 24-hour emergency dental services that meet professional standards and principles. Residents are assisted, when necessary, in making routine and annual appointments, arranging transportation and referral to a dentist in case of lost or damaged dentures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow infection control practices for 2 of 3 residents (R1, R5) reviewed for infection control. Findings include:R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body), pressure ulcer of right heel (diagnosis added 8/11/25), type 2 diabetes, and obesity. On 1/13/26, diagnoses of pressure ulcer of other site, pressure ulcer of unspecified, pressure ulcer of left buttock were included.R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had no cognitive impairments, no rejection of care, had an indwelling catheter and ostomy, had impairment on both sides of lower extremities, dependent for lower body care, maximum assistance to roll left and right, and dependent to transfer from surfaces. R1 was at risk of developing pressure ulcers/injuries but did not have any pressure ulcers and no open lesions. Treatments included pressure-reducing devices for chair and bed. R1 was not on a turning and reposition program, no nutrition or hydration interventions, and no dressing or treatments to feet.During an observation and interview on 1/26/26 at 10:58 a.m., director of nursing (DON)-B and clinical care leader registered nurse (CCLRN)-B went to R1's room. Both sanitized hands, applied gowns and gloves and entered room. CCLRN-B moved R1's bed, locked the brakes on the bed, used the remote for the bed and raised the bed. Area for wound supplies was not disinfected prior to placing supplies. CCLRN-B then removed heel boot and DON-B removed dressing on lateral left foot. CCLRN-B painted wound with betadine. DON-B directed CCLRN-B to remove gloves and sanitize hands. CCLRN-B applied clean dressing. CCLRN-B removed left heel dressing, applied betadine to heel and toes. CCLRN-B opened gauze package, and placed gauze between toes. Both removed gloves and sanitized hands. Removed boot and dressings to right lateral foot and heel. CCLRN-B changed gloves but did not sanitize hands. CCLRN-B applied betadine to heel, opened and put on new mepilex. Removed gloves and dated mepilex. Both sanitized hands. Rolled to right side and CCLRN-B removed dressing on left buttock, removed gloves, sanitized and applied new gloves. CCLRN-B applied a mepilex to area. CCLRN-B began removing dressing to wound vacuum site. CCLRN-B grabbed the suction machine and moved it, removed gloves and put new gloves on without sanitizing hands. CCLRN-B cleaning blood that is flowing from wound onto mepilex dressing on left buttock. DON-B came to the other side of the bed and assessed the wound, went to the other side of the bed, and handed CCLRN-B the sterile wound dressing in package. CCLRN-B removed gloves, sanitized, put on new gloves. CCLRN-B removed ointment lid, put ointment on q-tip, applied to wound bed, put lid on ointment, took out black foam and drape from the package, began cutting the foam, placed foam in wound, removed foam from wound, gave DON-B the unused foam, threw away the one that was in the wound, took the foam from DON-B, began trimming it, put hand in gauze package and removed a handful and began sponging the blood that was dripping from wound, got more gauze from the package of gauze, put the foam on wound. CCLRN-B then removed gloves, sanitized, applied new gloves. CCLRN-B applying drape but it was sticking to both of their gloves. Applied drape, cut a slit in the drape for the suction to be applied. The suction tubing had fallen on the floor and secretions from inside the tube were coming out onto the floor. CCLRN-B removed the canister from the suction machine and threw it in the garbage. CCLRN-B stated there was drainage at the bottom of the drape and needed to put more drape on. CCLRN-B removed the suction, placed new drape and cut a new slit for the suction. CCLRN-B grabbed more gauze from the package and alcohol wipes to wipe the mepilex next to wound vacuum site that had blood on it. CCLRN-B moved the remote control that was behind R1's back, grabbed the dirty wound supplies from the bed, threw in trashcan, removed gloves. Applied gloves without sanitizing and wiped the scissors with an alcohol wipe. DON-B removed gloves, sanitized and applied new (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves. CCLRN-B removed gloves, applied new gloves and went to R1's supplies and got him a new colostomy bag as his had fallen off while rolling. DON-B cleaned the blood from the floor, and advised CCLRN-B that the gauze package would need to be thrown away due to contamination from dirty gloves. Both removed gloves, gown, and sanitized when leaving room. RN-B entered the room wearing gloves but not a gown. RN-B removed Intravenous (IV) medication from R1's IV site, wiped the site, flushed IV with solution, removed gloves and left room. RN-B did not sanitize hands or change gloves after removing medication and did not wear a gown while performing these cares on R1. DON-B stated there is more work that needs to be done with infection control and wound care.R5R5's face sheet dated 1/20/26, identified diagnoses of Alzheimer's, dementia, and localized edema.R5's care plan dated 8/4/25, identified potential for pressure ulcer development related to terminal disease process, bladder incontinence, impaired mobility, and history of ulcers on sacrum. Interventions included to provide pressure redistribution cushion to manual wheelchair, and notify nurse of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. On 11/4/25, identified impairment to skin integrity related to edema and weeping of lower extremities. Interventions included monitor location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to physician.; keep skin clean and dry, use lotion on dry skin, do not apply to site of injury.During an observation on 1/20/26 at 8:23 a.m., R5 was in his recliner. RN-A is in room, waiting for assistance. Both CCLRN-A and NA-A entered room to assist. RN-A advised both to apply gown and gloves before assisting R5 with cares. CCLRN-A and NA-A placed a mechanical lift sling behind R5 and transferred him to the commode. NA-A placed a brief on wheelchair, got wipes and cleaned bowels. NA-A kept the same gloves on, removed sling straps from machine, manipulated R5's legs to removed the sling, attached brief, moving catheter bag around with both hands, touching catheter tubing, grabbed foot pedals, sat R5 up in wheelchair, took a blanket from R5's bed, placed it on him, moved hair from her mouth, put catheter holder on R5's leg, moved mechanical lift from in front of R5, took garbage, left room, returned with same gloves on, moved mechanical lift to hallway, moved commode to end of bed, moved to side of bed, picked up a pillow from the floor, put it on the bed, went to R5's bathroom, opened garbage bag, put bag in trashcan, opened catheter cover, lifted blanket on R5, removed straps to catheter cover, got on knees, touched catheter tubing, wheelchair, readjusted blanket on R5, untied gown from neck area, removed gloves, sanitized hands.During an observation on 1/20/26 at 9:09 a.m., CCLRN-A began wound care on R5's legs wearing a gown and gloves. Removed snacks from a plastic chair in room and sat in chair. Removed heel protectors from feet and stated they were soaked in bodily fluids. Removed dressings from left leg. Using the same gloves, CCLRN-A washed wounds with normal saline, washed heel, dropped gauze on floor, picked up gauze, washed back of leg wound. Removed gloves and applied a new pair. Opened dressing and put on the chair he had previously occupied, without disinfecting the chair. Wrapped leg with dressing. Removed dressings on right leg. Removed gloves, sanitized, applied new gloves. Wiped top wound with gauze pad, folded pad, wiped another wound, took another gauze from package and continued to wipe leg, removed gloves, sanitized, replaced gloves. Wrapped leg with dressing, removed gloves and sanitized hands.During an observation on 1/22/26 at 9:00 a.m., hospice nurse (HN)-A went to R5's room to assess wounds on buttocks. HN-A wore gloves but no gown when obtaining R5's vital signs. Licensed practical nurse (LPN)-B came in room with medications and fed them to R5 without a gown or gloves on. Both nurses applied gown and gloves. Rolled R5 towards the window, removed dressing to buttocks. LPN-A went to R5's drawer, removed dry wipes, went to bathroom and wet them with water from the sink, washed buttocks. Both nurses touched R5's buttocks. LPN-A applied cream to buttocks and placed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 Sixth Street Windom, MN 56101

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing over wound. HN-A moved wound care supplies from overbed table. LPN-A got a catheter cover and placed on R5's catheter. Neither nurse removed gloves and sanitized hands between touching clean and dirty surfaces.During an interview on 1/20/26 at 1:18 p.m., NA-A stated gloves should be changed if soiled, when doing a different task, after wiping a resident, should not go in hall with gloves on.During an interview on 1/20/26 at 10:44 a.m., CCLRN-A stated it was definitely an infection control issues with wearing dirty gloves.During an interview on 1/22/6 at 12:14 p.m., director of nursing (DON) stated following enhanced barrier precautions and infection control was confusing.