

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Windom		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764</p> <p>Based on observation, interview, and document review, the facility failed to ensure residents were provided care in a dignified and respectful manner for 1 of 3 residents (R13) who were observed during care interactions.</p> <p>Findings include:</p> <p>R13's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R13 had moderately impaired cognition, had no rejection of care, was frequently incontinent of bladder, always continent of bowel, had a bowel toileting program, and was dependent for toilet transfers and toileting hygiene.</p> <p>R13's care plan dated 11/14/24, indicated a history of bowel incontinence related to loss of sensation, impaired mobility, needing staff assistance with transfers with a goal of 20 or less incontinent episodes of bowel movements through the next review date, constipation related to decreased mobility, frequent bladder incontinence related to stroke side effects with a goal of being continent of bladder during waking hours through the review date. R13's care plan further indicated a bowel toileting program with scheduled toileting times of 12:30 a.m., 6:45 a.m., 8:30 a.m., 1:00 p.m., 4:00 p.m., and 7:00 p.m.</p> <p>During observation on 12/11/24 at 7:29 a.m., nursing assistant (NA)-E answered R13's call light. R13 stated she needed to use the commode. NA-E told R13 she had just gotten up and R13 would have to wait until after breakfast because NA-E was too busy getting people up. NA-E told R13 she should have asked to use the commode when she got up for the day. NA-E assisted R13 to the dining room in her wheelchair without assisting her to the commode per R13's request.</p> <p>During interview on 12/11/24 at 7:32 a.m., NA-E stated she told R13 she had to wait because she didn't have time to put her on the commode every 5 minutes. NA-E further stated R13 was jealous of NA-E helping other residents and turned her light on out of jealousy and attention. NA-E then stated R13 was always asking for something.</p> <p>During interview on 12/11/24 at 7:35 a.m., R13 stated she needed to use the commode but was told to wait until after breakfast. R13 further stated she was frequently told staff didn't have time in the morning and often could not use the commode when requested. R13 stated she had been embarrassed due to being incontinent in her brief due to having to wait to use the commode until after breakfast.</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:	Facility ID: 245558
		If continuation sheet Page 1 of 9

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 12/11/24 at 7:39 a.m., NA-D stated she would assist a resident if they requested to use the commode and if she was too busy, she would ask a different NA to help or would tell her charge nurse. NA-D further stated she would not tell a resident they could not use the commode when requested.</p> <p>During interview on 12/11/24 at 7:42 a.m., registered nurse (RN)-C stated he expected residents to be able to use the commode when requested and if the NA was too busy they could ask another NA for assistance or ask a nurse to help. RN-C further stated residents should use the commode when requested.</p> <p>During interview on 12/11/24 at 9:34 a.m., licensed practical nurse (LPN)-A stated she would expect residents to use the commode when requested and if the NA was busy they could tell the resident they would be with them as soon as possible or request help from another NA or the nurse. LPN-A further stated it was not acceptable to tell a resident they had to wait until after breakfast to use the commode.</p> <p>During interview on 12/11/24 at 11:36 a.m., director of nursing (DON) stated she would not expect a resident to be told they couldn't use the commode and would expect the request to be honored, and if the NA was overwhelmed they could tell the resident they would be with them as soon as possible, ask another NA for assistance, or inform their charge nurse of the need for assistance.</p> <p>During observation on 12/11/24 at 8:23 a.m., R13 was assisted back to her room from breakfast and her call light was illuminated. NA-D entered R13's room and assisted her to the commode.</p> <p>During interview on 12/11/24 at 8:52 a.m., NA-D stated R13 was incontinent of urine in her brief prior to using the commode and had a bowel movement in the commode.</p> <p>A review of NA-E's training record printed 12/11/24, indicated NA-E was trained in [NAME] Health Nursing Assistant Training program, Changing the Culture to Person-Centered Care, Activities of Daily Living, and Communicating Effectively.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614</p> <p>Based on observation, interview and document review, the facility failed to provide services to restore, maintain and prevent loss of range of motion (ROM) for 1 of 1 resident (R10) reviewed for limited ROM.</p> <p>Findings include:</p> <p>R10's facesheet printed 12/11/24, identified diagnoses of Parkinson's disease (brain disorder that causes unintended or uncontrollable movements), dementia, polyneuropathy (nerves that affects the skin, muscles and organs are damaged and can't sent signals back to the brain) and peripheral vascular disease (veins/arteries in the arms, hands, legs and feet have restricted blood flow).</p> <p>R10's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R10 had severely impaired cognition, limited range of motion of both upper and lower extremities on both right and left sides, dependent on staff for eating, and all activities of daily living.</p> <p>R10's care plan dated 6/2/24, indicated R10 had a need for a functional maintenance program due to limited mobility in left fingers/palm. Goal included resident will remain free of complications related to immobility of left fingers and skin break down through the next review date. Interventions included complete passive range of motion (PROM) to left digits while wrapped in warm towels. Place palm splint on after PROM. Complete 10 repetitions, three times per week as needed and as tolerated.</p> <p>A physician order dated 5/15/24, included remove brace from left hand at bedtime for hand contracture.</p> <p>A occupation therapy (OT) Therapist Progress and Discharge Summary dated 5/31/24, by OT-B indicated caregiver is able to assist patient to complete PROM program for bilateral upper extremities (BUE) and wrist to reduce pain, avoid contractures, and maintain functional use of BUE. Patient has met goal of palm protector for left upper extremity to reduce pain, avoid contractures, and promote safe hand hygiene. Caregivers have been educated on strategies for safe use of palm protector and for PROM exercises to maintain current function of patients BUE.</p> <p>A Therapy Documentation Note dated 5/31/24, by certified occupational therapy assistant (COTA)-C, included complete PROM on left digits while wrapped in warm towels. Place palm splint on patient after PROM one to three time per week as tolerated.</p> <p>During observation on 12/9/24 at 3:26 p.m., R10 was lying in her bed. R10's left hand was in a fist with no splint present. R10, upon request to move her left fingers, was able to move all but her middle digit approximately 1/2 an inch. R10's right hand's fingers were curled towards her palm with fingers touching her palm. R10's right wrist was also positioned prone at 30 degree angle. R10 was not able to move her fingers or her wrist on right side.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation on 12/10/24 at 9:26 a.m., R10 was lying in her bed awake. No splint was present on her left hand. Left fingers were curled into palm of hand in a fist position. Right hand was curled into a fist and right wrist remained positioned downwards at 30 degree angle.</p> <p>On interview 12/10/24 at 9:52 a.m., nursing assistant (NA)-A indicated R10 is supposed to wear a splint but couldn't find it this morning. NA-A stated she doesn't do ROM on R10's hand and doesn't believe NA's do that and restorative aide is responsible for completing that task.</p> <p>On interview 12/10/24 at 11:10 a.m., nursing assistant (NA)-B, also identified as restorative aide, stated range of motion (ROM) is done every time the brace is put on because it takes the warm towels to loosen R10's fingers to put the brace on. NA-B indicated the brace should be put on every morning but she was unable to locate it this morning or yesterday. NA-B indicated when she is scheduled for restorative aide duties, she always stops in the morning and ensures ROM done and splint are applied, but NA-A stated she gets pulled from restorative duties frequently including the past two weeks. NA-B indicated the ROM and splint are only ordered for her left hand and not her right hand, but stated it looked like her right hand could use ROM and a splint also.</p> <p>On interview 12/10/24 at 1:46 p.m., licensed practical nurse (LPN)-B wasn't sure if R10 was supposed to be wearing a splint. LPN-B indicated she has noted R10's right hand is also contracted and she should probably get an order for therapy for evaluation.</p> <p>On 12/11/24 at 7:18 a.m., LPN-A stated ROM is completed on both R10's hands and she does have a splint for her left hand.</p> <p>During interview and observation on 12/11/24 at 7:38 a.m., LPN-B indicated the NA's can complete ROM but if the restorative aide is available she will complete it and apply R10's splint. Upon request LPN-B assessed R10's hands and indicated R10's right hand/fingers was not as contracted as they currently are the last time she evaluated them (was not able to identify when last evaluated) and added she will get an order for therapy to evaluate. R10 did not have a splint on her left hand and LPN-B stated sometimes the left hand splint doesn't get applied until later in the day.</p> <p>During observation on 12/11/24 at 8:01 a.m., R10 is in the dining room with no splint on her left hand. Fingers continue curled into palms on both the right and left hands.</p> <p>During interview and observation on 12/11/24 at 8:19 a.m., occupational therapist (OT)-B, after reviewing notes from previous sessions April and May 2024, indicated R10 should be getting PROM to both hands and should wear a splint on her left hand throughout the day. OT-B stated R10 was not able to complete active range of motion, had zero strength on both hands and had facial grimacing with PROM of her left hand. Recommendations included PROM to both upper extremities. OT-B indicated written recommendations are given to the nursing staff upon discharge for recommendations to be completed for continued exercise program. At 8:36 a.m., OT-B completed evaluation of R10's hands. OT-B indicated no real change present on her left hand, however, R10 had no discomfort with PROM with her right hand during previous visit in April and May 2024, and now she does. OT-B added as soon as releasing fingers, they immediately returned to a curled position which could also indicate worsening of the motion in R10's right hand. OT-B indicated measurements of movement were never completed so it is difficult to state if her right hand/fingers/wrist are worse and can only base it on grimace on R10's face with passive movement. OT-B indicated with any change in either of R10's hands, a referral should be completed for OT evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation on 12/11/24 at 12:40 p.m., R10 is in her room in her Broda chair (positioning chair) with no splint on her left hand.</p> <p>Facility Restorative Splinting policy dated 5/21/24, included:</p> <ul style="list-style-type: none"> -Check electronic medical record (EMR) for resident specific restorative interventions -If care planned, provide ROM exercises to decrease muscle tone prior to application of splint <p>Apply the splint as directed by physician and/or therapist instruction.</p> <p>A policy on ROM was requested but not received.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614</p> <p>Based on observation, interview and document review, the facility failed to follow standards of care and practice for use of an indwelling catheter for 1 of 1 resident (R15) who used an indwelling catheter.</p> <p>Findings include:</p> <p>R15's facesheet, printed 12/11/24, included diagnoses of ulcerative proctitis (inflammatory bowel disease affecting only the rectum), insomnia, and hypothyroidism. There was no medical diagnosis indicating indication or rationale for Foley catheter.</p> <p>R15's quarterly Minimums Data Set (MDS) assessment dated [DATE], included moderately impaired cognition, requires partial to moderate assistance for toilet transfer, is continent of bowel and has an indwelling catheter. R15 does not have post void (urination) residuals greater than 250 cc.</p> <p>R15's Catheter Data Collection dated 11/15/24, indicated continued use of indwelling catheter. Reason for catheter was overactive bladder. Indications for use of catheter was checked as other with specify other left blank.</p> <p>R15's plan of care dated 8/27/24, indicated R15 had an indwelling catheter related to overactive bladder with hygiene issues and causes anxiety. Interventions included monitor and document for pain/discomfort due to catheter, monitor for signs and symptoms of discomfort on urination and frequency, indwelling 16 french Foley catheter with 5 cc balloon, document output every shift, monitor/record/report to health care provider for signs of urinary tract infection, catheter care by nursing assistant with morning and evening cares, wear leg bag during the day and straight catheter drainage bag at night and report any unusual observations/conditions to the nurse.</p> <p>During observation and interview on 12/9/24 at 4:14 p.m., R15 was sitting in her room in her wheelchair. R15 stated she currently has a urine infection and she was told by her doctor her bladder doesn't work anymore and she gets frequent infections. R15 stated she has had problems for years with urinary tract infections and has seen multiple doctors for this in the past.</p> <p>During observation and interview on 12/10/24, at 9:15 a.m., R15 stated her doctor told her she needs to have a catheter because her bladder doesn't work anymore. R15 stated they put the catheter in about two months ago.</p> <p>During observation and interview on 12/11/24 at 7:10 a.m., nursing assistant (NA)-A indicated R15 has had a catheter a few months now but is unsure why she has one.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 12/11/24 at 7:31 a.m., licensed practical nurse (LPN)-A indicated R15 has had a lot of urinary tract infections (UTI's), so R15's physician ordered a catheter to see if it would help. LPN-A stated R15 has had one UTI since the catheter placement but feels this is less than previously. LPN-A stated the catheter is permanent and was not aware if post residual urine scans (amount of urine left in the bladder after urination completed by ultrasound scan of bladder) were ever performed or if she has seen a urologist. LPN-A contacted registered nurse (RN)-A, also identified as clinical leader, via phone. RN-A indicated R15 was given medication to try to empty R15's bladder but no tests were completed to see if bladder was emptying. RN-A stated a family member and R15 went to regular provider check up and asked if R15 could have a catheter to see if it would help with UTI's. RN-A indicated the provider listed reasons why she should have a catheter and placed an order for the Foley catheter.</p> <p>A provider note dated 7/15/24, included R15 has urinary incontinence 24/7. R15 indicated she can not make it to the bathroom and simply voids into pads and often has to wear multiple pads when she is out and about. R15 denies burning with urination, fever, chills, flank pain, suprapubic discomfort or change in urine itself. Discussed the possibility of an indwelling Foley. This would allow her to remain dry and not have to worry about being up and about. At the same time we discussed the fact that it is a foreign body and can increase the likelihood of infection. It may also cause bladder spasm, etc. It is not a perfect answer but one that has been considered in the past and one she would like to consider now. Suggested this begin no sooner than following an upcoming wedding, thus we will start the indwelling Foley catheter on 8/5/24.</p> <p>A provider order dated 7/15/24, indicated R15 to have an indwelling Foley placed to leg bag on 8/5/24 or thereafter. This is to be a permanent solution to her incontinence.</p> <p>During interview on 12/11/24 at 12:05 p.m., the director of nursing (DON) stated R15's diagnosis does not meet standard of care for a Foley catheter but added quality of life is important. The DON indicated R15 has not had a urology consult since she has been a resident at the facility.</p> <p>Facility Urinary Catheter policy dated 11/28/22, included:</p> <p>- An order and indication is required for an indwelling Foley insertion. Consider Foley catheter alternatives (i. e. external catheters and intermittent catheterization).</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>44630</p> <p>Based on observation, interview, and document review the facility failed to maintain a system to analyze monthly surveillance data for trends and patterns to reduce the spread of illness, infections, control transmission of infections and communicable diseases present in the facility. This had the potential to affect all 53 residents who resided in the facility.</p> <p>Findings include:</p> <p>Document titled Monthly Infection Summary August 2024, September 2024, November 2024, indicated resident name, start date, date symptoms resolved, type of infection, status, antimicrobial, infection source and surveillance of criteria met. No mapping or trending of the data was provided.</p> <p>On 12/11/24 at 10:32 a.m., during an interview registered nurse (RN)-B stated she was the infection nurse at the facility. RN-B stated she was responsible for overseeing the facility's infection control program and maintaining the facility's infection control surveillance log. RN-B stated the infections were tracked and documented on the computer tracking form, but no ongoing formal surveillance, monitoring of trends and/or breaks in infection practices had occurred. When asked to review the infection data, RN-B used the tracking form on the computer and identified the infection control logs for the past few months. RN-B verified anything she had done regarding infection prevention was on done on an informal basis and confirmed the information was not tracked or analyzed. RN-B stated she was still in the process of learning all the components of infection preventionist role. RN-B stated infection data was reviewed at the end of the month and reviewed with the quality committee,</p> <p>On 12/11/24 at 11:08 a.m., the director of nursing (DON) verified the facility's infection surveillance was not comprehensive and residents were not tracked or compared for trending's or patterns The DON verified a monthly analysis of the illnesses and infections was important to rule out any trending or patterns, and interventions could be initiated to help prevent illness or infections including staff education and system process review. The DON verified the facility had not completed infection surveillance that included data collection, analysis of facility infections, tracking and trending of infections or illnesses within of residents or staff within the facility.</p> <p>Facility Infection Prevention and Control Program policy dated 12/2/24, indicated:</p> <p>To establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections.</p> <p>Surveillance</p> <p>The facility's surveillance system includes the data collection tool and then use of nationally recognized surveillance criteria to define infections.</p> <p>-resident infection surveillance is completed in the infection and antimicrobial tracking tool</p> <p>-resident infection surveillance is completed in safety zone</p> <p>(continued on next page)</p>		

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