STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview, and record review, the facility failed to accommodate the needs for 1 of 1 residents (R1) who required a two-handled cup for drinking liquids. Findings include: R1's admission Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses of quadriplegia, fracture of neck and dysphagia. R1's care plan revised on 1/5/24, directed staff to place table over bed lined up with paper on the wall, in front of R1 but not over his hands. R1 requires moderately thick water to be on the table in a double handled cup with a lid. On 2/6/24 at 4:51 p.m., R1 was observed laying in his bed which was along the wall, bed side table was noted to be in the middle of the room and had a one handled water pitcher on it. There was a bright orange sign posted on the wall, on R1's right side, that directed staff to place bedside table lined up with the paper and moderately thick water to be placed on the table in a double handle cup with a lid. There was also a plastic disposable cup with thickened water placed on R1's nightstand. R1 confirmed he was not able to reach either cup of water without having to call for staff assistance. On 2/6/24 at 5:06 p.m., nursing assistant (NA)-A and NA-B enter R1's room to assist R1 and upon exiting R1's room NA-B offered R1 a drink from the plastic disposable cup however, R1 declined. After exiting the room, NA-B was asked about the sign posted to R1's wall, however NA-B was unaware of the sign. NA-B stated she had never seen R1 have a double handled cup and was unaware he required one. NA-B stated usually R1 had a one handled mug and a disposable plastic cup with thickened water in his room. NA-B continued to walk down the hallway and did not return to R1's room with a two handled cup of thickened water and did not move R1's bedside table to be within reach of R1. At 5:56 p.m., R1 continued to be in his room, bed side table remained in the middle of his room with a one handled pitcher on it and out of reach for R1. On 2/7/24 at 2:21 p.m., NA-C stated R1 required moderately thick liquids with a double handled cup and staff were directed to ensure bed side table within front of R1 within reach. On 2/7/24 at 3:40 p.m., licensed practical nurse (LPN)-A stated R1 required thickened liquids in a two handled cup due to limited movement in his arms. (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: 245568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/8/24 at 10:06 a.m., registered nurse (RN)-A stated R1 was admitted to the facility following an accident which resulted in a neck fracture and now was unable to move legs and had some movement of arms. R1 required thickened liquids in a two handled cup so he would be able to independently take a drink when desired. On 2/8/24 at 1:15 p.m., director of nursing (DON) stated R1 required total assistance by staff for activities of daily living (ADLs). Further, DON stated R1 required thickened liquids in a two handled cup as the handles were easier for R1 to grab onto with his limited mobility of arms and hands. Review of facility policy titled Care Plan revise 11/1/23, revealed each resident would have individualized, person-centered, comprehensive plan of care that would include measurable goals directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview, and document review the facility failed to ensure an injury of unknown was consistently assessed and monitored for healing progress for 1 of 3 residents (R1) reviewed. Findings include: R1's admission Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses of quadriplegia, fracture of neck and dysphagia. R1's care plan revised on 1/4/24, indicated R1 was at risk for pressure ulcer development and R1 always required heel protectors on while in bed. R1's physician progress note dated 1/9/24, revealed R1 was assessed, and no skin concerns were identified. R1's Skin Observation revealed: -On 1/21/24, R1 was noted to have a small brown area on left heel. -On 1/28/24, lacked evidence of R1's heel progress. -On 2/4/24, R1's left outer heel had a small, scabbed area. R1's Wound Data Collection dated 2/6/24, indicated R1 had a distal scabbed area on left heel and was noted to be 2 centimeters (cm) in length and 1 cm wide. Scab was noted to be firmly attached and no redness or drainage was noted. Further, documented indicated scabbed area was left open to air and heel protectors were on. On 2/8/24 at 1:15 p.m., director of nursing (DON) stated R1 was at risk for developing pressure ulcers due to diagnosis or paraplegia as well as incontinent of bowel. DON stated she was made aware of the wound on R1's heel on 1/17/24 by R1's family. DON stated she observed and assessed the wound on 1/17/24 and noted there was a small, scabbed area. DON stated she was unsure how R1 obtained the wound on his heel, since R1 was quadriplegic and unable to move his legs and required heel protectors on while in bed. DON stated she only interviewed staff that were on shift on the evening of 1/17/24 when she was made aware of the scab and did not have evidence for those interviews. R1's record lacked evidence of an incident occurring between 1/9/24, when R1 was assessed by a physician, and 1/17/24, when facility management were made aware by family of a wound on R1's ankle. R1's record lacked evidence of new and/or revised interventions following a new wound on his ankle as well as any additional staff monitoring/auditing to ensure staff were utilizing R1's heel protectors appropriately to prevent wounds on R1's ankles. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Abuse and Neglect revised on 7/6/23, indicated the investigation team will review all incidents no later than the next working day following the incident, ensure someone was assigned to complete the investigation and that the care plan has been updated with any new interventions. Further, policy indicated the investigation may include interviewing employees, residents or other witnesses to the incident, interview all involved including the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview, and document review the facility failed to ensure an injury of unknown was consistently assessed and monitored for healing progress for 1 of 3 residents (R1) reviewed. Findings include: R1's admission Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses of quadriplegia, fracture of neck and dysphagia. R1's care plan revised on 1/4/24, indicated R1 was at risk for pressure ulcer development and R1 always required heel protectors on while in bed. R1's physician progress note dated 1/9/24, revealed R1 was assessed, and no skin concerns were identified. R1's Skin Observation revealed: -On 1/21/24, R1 was noted to have a small brown area on left heel. -On 1/28/24, lacked evidence of R1's heel progress. -On 2/4/24, R1's left outer heel had a small, scabbed area. R1's Wound Data Collection dated 2/6/24, indicated R1 had a distal scabbed area on left heel and was noted to be 2 centimeters (cm) in length and 1 cm wide. Scab was noted to be firmly attached and no redness or drainage was noted. Further, documented indicated scabbed area was left open to air and heel protectors were on. On 2/7/24 at 8:30 a.m., family member (FM)-A stated on the day of R1's care conference, R1 had a pressure ulcer on his left heel and FM-A had reported it to staff as well as reiterating the importance of staff utilizing R1's heel protectors while he was in bed. FM-A stated staff were not aware of R1's heel and there had been nothing documented at that time in R1's medical record regarding his heel. On 2/7/24 at 2:21 p.m., nursing assistant (NA)-C stated R1 required total assistance with all activities of daily living (ADLs). Further, NA-C stated R1 had one sore on his heel and required heel protectors on while he was in bed. On 2/7/24 at 3:06 p.m., NA-B stated R1 was required to wear heel protectors while in bed however was not aware of any wounds on R1's heels. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/7/24 at 3:40 p.m., licensed practical nurse (LPN)-A stated licensed nursing staff were expected to complete a skin assessment at least weekly and when no skin impairments are observed. LPN-A stated if there are new skin impairments noted, registered nurse (RN)-A would be notified as well to assess the resident. Further, LPN-A stated R1 was quadriplegic and required heel protectors. LPN-A stated there was no open sore on R1's heel currently. On 2/8/24 at 9:04 a.m., LPN-B stated R1 had a small circle wound on his heel but had not seen his heel for a while so was unsure what it currently looked like. LPN-B stated the would was pressure related due to R1 spending prolonged time in bed however R1 always wears heel protectors. At 9:13 a.m. LPN-B entered R1's room, removed R1's heel protector and stated there was an area on his left heel that appeared to be scabbed over and looked like it was healing. On 2/8/24 at 10:06 a.m., RN-A stated a skin observation assessment would be expected to be completed by a licensed nurse weekly on each bath day and if something new was noted. A wound assessment would be completed if a wound was identified which would be completed by the resident's case manager. Further, RN-A stated R1 was admitted to the facility following a fall which resulted in a neck fracture, and R1 was unable to move his legs but had some movement in his arms. RN-A stated she was made aware of R1's wound on his heel in January and stated the wound could be pressure related but looks like a regular scab currently. RN-A stated R1 was at risk for pressure ulcers and staff were to apply heel protector boots onto both of R1's feet. RN-A stated staff were utilizing R1's heel protector boots but was unsure how a wound could have occurred on R1's heels but stated the wound has not changed since RN-A first saw it on 1/17/24. RN-A was unsure what could have caused the wound on R1's heel and stated the wound could be pressure related or and incident had occurred with staff bumping R1's ankle on something. However, RN-A had not received any incident reports regarding any incidents. Further, LPN-A confirmed once R1's wound on his left heel was identified, the licensed nurse should have been monitoring the wound at least weekly and documenting the assessment in R1's medical record. On 2/8/24 at 1:15 p.m., director of nursing (DON) stated R1 was at risk for developing pressure ulcers due to diagnosis or paraplegia as well as incontinent of bowel. DON stated she was made aware of the wound on R1's heel on 1/17/24 by R1's family. DON stated she observed and assessed the wound on 1/17/24 and noted there was a small, scabbed area. DON stated she did not think R1's wound was pressure related but was unsure if a licensed nurse completed an assessment in R1's medical record regarding the wound. Further, DON stated if a wound was identified, RN-A would be expected to complete a weekly wound assessment until the wound was healed. Review of facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation revised on 4/26/23, directed staff if a bruise, contusion, skin tear, or abrasion was noted it should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation assessment and on the resident's care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview, and document review the facility failed to provide an altered diet as prescribed for 1 of 2 residents (R3) reviewed for nutrition. Findings include: R3's quarterly Minimal Data Set (MDS) dated [DATE], indicated R3 had diagnoses which included dementia, diabetes, and dysphagia. Further, MDS revealed R3 had severely impaired cognition and required a mechanically altered and therapeutic diet. R3's physician orders dated 10/2/23, indicated R3 required a pureed textured diet. R3's care plan as of 2/6/24, indicated R3 was able to independently eat at times however required cues from staff as R3 was noted to stop chewing. Staff were expected to assist R3 was eating if needed and give R3 small bites. On 2/6/24 at 5:45 p.m., R3 was served her dinner plate by dietary aid (DA)-A. Nursing assistant (NA)-A was seated on R3's right side, assisting R3 with her meal. NA-A was noted to say R3 would not eat for NA-A. R3 was observed to have mashed potatoes and pasta noodles with red sauce on her plate. NA-A stated she was assisting R3 with her meal but was unsure what kind of diet R3 required. At 5:51 p.m., NA-B confirmed R3 required pureed food and stated, she was unsure why her pasta was like everyone else's and was so noodly. NA-B removed R3's dinner plate and brings the plate to the kitchen window where director of nursing (DON) was standing and stated R3 needed a new plate as she required pureed food. At 5:54 p.m., NA-A confirmed R3 did not eat any of the pasta, but NA-A attempted to give R3 bites of the pasta. DON brought R3 a different plate with pureed food. R3 was not observed to be coughing or in any distress during the observation. On 2/7/24 at 12:02 p.m. cook (C)-A stated the cook would be expected to dish each resident's meal according to their diet order which was located at the top of each resident's diet card. Prior to giving the plate to the resident, staff would be expected to verify the plate was the correct diet and the plate was going to the correct resident. On 2/7/24 at 1:49 p.m., C-B stated staff were expected to refer to each resident's dietary order that was listed on their dietary card while dishing up food to the plate. Once the food was on the plate, the plate and card were given to the next staff who would then ensure they have the right person and the correct diet. On 2/7/24 at 1:52 p.m., C-C stated each resident's diet order was on their dietary card that staff were expected to reference while dishing up the resident's plate. C-C stated the plate then was handed to another staff and they are expected to verify the plate matches the diet order and the correct resident prior to serving the resident the plate. Further, C-C stated on the evening of 2/6/24, the two dietary aids began to lay out the dietary cards for the cook and they would get them mixed up. C-C stated she recalled R3's plate returning to the kitchen as it was not the correct diet or the correct resident the plate was given too. C-C stated on that same evening this happened approximately 2-3 times plates were brought back due to the dietary aids not paying attention and not jiving. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/7/24 at 2:21 p.m., NA-C stated each resident's diet was listed in their chart in the electronic record system as well as the dietary staff had dietary cards that listed the diet order as well. NA-C stated each staff would be expected to verify the dietary card prior to serving the plate to the resident to ensure they receive the correct diet. Further, NA-C stated R3 required pureed food and was not aware of any incidents of R3 choking or not receiving the correct diet. On 2/7/24 at 3:06 p.m., NA-B stated each resident's diet was listed on their care plan or on their dietary card. However, NA-B stated if staff were assisting a resident at the table and did not assist with serving the plate or if the staff was new, staff would not be aware of the resident's diet order as the staff who delivers the plate to the resident would be expected to verify the plate with the diet order prior to serving the plate and takes the dietary card back to the kitchen. Further, NA-B stated she was unsure what had exactly happened on 2/6/24,but stated the dietary aids did not do their double check to verify it was the correct resident and correct diet prior to serving when R3 was served a regular diet meal instead of pureed. NA-B stated there have not been any incidents of R3 choking that she was aware of. On 2/7/24, DA-A stated each resident had their own dietary card which staff would be expected to verify the plate with the dietary card to ensure they match prior to delivering the plate to the resident. Further, DA-A stated on the evening of 2/6/24, was chaotic and confirmed he did not complete the double check to verify the diet order and the plate matched prior to serving R3 her meal. On 2/7/24 at 3:29 p.m., DON stated the cook was expected to verify resident's diet order when dishing up their plate, then hand the plate and dietary card to another staff member who will look at the dietary card and plate and verify the correct diet and deliver the plate to the resident. DON stated she was aware R3 did not receive pureed diet and has since re-educated all staff on the facility process for verifying diets. Review of facility policy titled Diet Orders- Food and Nutrition revised 5/3/23, revealed a diet card is a communication tool that informs employees of resident diet information and preferences. The policy lacked staff direction of meal delivery process to ensure resident's receive correct diet per physician orders.