STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	01/14/2025

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. 39988 Based on interview the facility failed to ensure resident mail was delivered consistently on Saturdays for 2 of 2 residents (R18, and R25) who voiced concerns with mail delivery. This deficient practice had the potential to affect all 37 residents residing in the facility. Findings include: R25's 12/11/24, Significant Change in Condition Minimum Data Set (MDS) assessment identified R25's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 15. Interview on 1/13/25 at 1:10 p.m., during the Resident Council meeting, R25 identified he did not always get mail on Saturdays because there was only one activity staff who worked on Saturdays so there were times when his mail was not delivered until Sunday or Monday. R18's 12/10/24, Significant Change in Condition MDS assessment identified R18's cognition was intact with a BIMS score of 15. Interview on 1/14/25 at 7:34 a.m., with R18 identified she did not receive mail every Saturday and it was a hit or miss as the activity staff were only here long enough to help feed residents at noon and then they left. Interview on 1/13/25 at 1:26 p.m., with social worker designee/activity director identified the mail was brought to the front desk and activity staff delivered the mail Monday through Saturday and there was no mail delivery on Sundays. She reported there was always activity staff working on Saturday however, if the mail came after the activity staff left for the day residents did not receive their mail until Monday morning. She identified that did not happen very often. She revealed the maintenance director brought the mail to the reception desk and placed it in a white basket daily and the activity staff delivered it. She confirmed that the maintenance director was the only staff member who picked the mail up out of the actual mailbox. Interview on 1/13/25 at 1:30 p.m., with the maintenance director identified he picked the mail up out of the mailbox located outside of the facility Monday through Friday and dropped it off at the receptionist desk. (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 01/14/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Mary Jane Brown		STREET ADDRESS, CITY, STATE, ZIP CODE 110 South Walnut Avenue Luverne, MN 56156	

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/13/25 at 1:40 p.m., with the administrator in training (AIT) identified if the mail was delivered on Saturday by the post office that anyone from the facility could pick it up from the mailbox and deliver it to the residents. She reported her expectation was that if the post office delivered mail on Saturday, then the residents would receive their mail on Saturday. Interview on 1/13/25 at 1:44 p.m., with social worker designee/activity director revealed that mail at times was delivered after 5:00 p.m., on Saturdays and that was the reason the residents not receive their mail until Monday. A mail service policy was requested but not provided. A policy for Resident Mail and Parcel Services for Senior Living and Affordable Housing policy was provided but did not include long term care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47497 Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R11) care plan was revised to show meal preferences. Findings include: R11's 12/16/24, significant change Minimum Data Set (MDS) assessment identified his cognition was moderately impaired, he required limited assistance with transfers and activities of daily living (ADL's). R11 had diagnosis of dementia, diabetes, Parkinson's disease, and anxiety disorder. Interview on 1/12/25 at 11:42 a.m., with family member (FM)-A identified she has told staff several times that he does not like fish or turkey, but they continue to serve it to him. Review of R11's nutritional assessment identified multiple foods that R11 did not like but made no mention of his request not to be served fish. R11's current care plan identified a nutritional focus with a goal for R11 to express that his nutritional needs are being met and that he feels supported. The staff were to discuss coping behaviors related to self-image concerns, he prefers to dine in his room, uses adaptive equipment and staff should monitor and report any signs of difficulty chewing or swallowing. The care plan made no mention of R11's food likes or dislikes. Observation and interview on 1/12/25 at 5:50 p.m., R11 was eating supper in his room, he identified he did not like fish and pointed to his sandwich. He said the sandwich was tuna fish and tasted like slop. Interview on 1/12/25 at 6:01 p.m., with nursing assistant (NA)-C identified residents get a menu slip each morning at breakfast to fill out their meal choices for the day. At the bottom of the slip, it lists dietary preferences and on the back, it lists the any-time menu options. Interview on 1/12/25, at 6:10 p.m., with cook-A identified the nursing assistants bring the menu slips to the kitchen and the cook reviews them as they are preparing the meal trays. Cook-A retrieved R11's menu slip for supper meal and revealed it was blank. Cook-A identified that R11's slip is often blank when it is returned to the kitchen. Observation of R11's menu slip identified the any-time menu items were not listed on his slip. R11's dietary preferences were listed at the bottom, however, there was no mention of his dislike of fish. R11's current treatment record identified a physician order for nursing to check with resident about meal choice, they were to be specific about each option on the menu and what foods he would like staff to cut up. They were to communicate R11's choices to the nursing assistant that is gathering menu slips so that it can be passed on to the kitchen due to his swallowing issues. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/13/25 at 8:23 a.m., with the dietary manager (DM)-F identified he asks about preferences at the care conference meeting. He lists the preferences on each resident's diet card. The diet cart is a laminated card used in the kitchen while preparing meal trays. He revealed that R11's dietary card has NO FISH noted on the card, he agreed that R11 did receive fish at supper during the evening meal on 1/12/25. DM-F also identified that he was not aware that R11's menu slips were not being filled out prior to being returned to the kitchen. Observation of R11's laminated dietary card had noted NO FISH noted on the bottom left corner. A policy was requested but not provided by the end of the survey.

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34083

Based on observation, interview, and document review, the facility failed administer 1 of 1 medication (levothyroxine) according to labeled instructions for 1 of 25 medication administration observations.

Findings include:

Observation and interview on 1/13/25 at 8:29 a.m., with licensed practical nurse (LPN)-A as she obtained R 92's Levothyroxine 150 micrograms (mcg) from the medication cart. The order on the electronic medical record (MAR) identified: (Levothyroxine) Synthroid Oral tablet 150 mcg 1 tablet by mouth (PO) one time a day (QD) before breakfast. LPN-A removed the card containing the medication, checked it against the MAR and punched out a pill into the medication cup. The label on the bubble pack directed take 1 tablet PO QD before breakfast. Do not take with Iron, Aluminum, Magnesium, or Calcium containing products. LPN-A returned the card to the medication cart and continued dispensing R92's medications into the same medication cup. R92's medications in the same med cup included: Calcium 600 mg/D3 (Calcium supplement with vitamin D) 2 tablets PO Q AM, and Ferrous Sulfate (iron supplement) 325 milligrams (mg) PO Q AM. LPN-A took the cup containing the medications to R92's room and administered the cup of medications. Upon returning to the cart to document administration of the medications, LPN-A reviewed the levothyroxine. LPN-A reported she had not noted the instructions printed on the Levothyroxine label to not administer with Iron or calcium. The instructions had also not been included in the MAR. She reported she had not noticed the additional instructions printed on the Levothyroxine label and had always administered all of R92's morning medications at the same time. The instructions should have been included in the MAR and the Calcium/vitamin D and Ferrous Sulfate should have been scheduled at a different time.

Interview on 1/13/25 at 8:40 a.m., with LPN-A identified she had checked the medication card against the MAR and determined it was the correct medication, but she had not noted the additional printed instructions. LPN-A would give the medication card to the charge nurse to be corrected in the MAR to ensure the error did not continue.

Interview on 1/13/25 at 8:50 a.m., with the interim director of nursing (IDON) identified staff passing medications were expected to be reading and comparing medication cards against the MAR and if there was a discrepancy then checking with the charge nurse, and pharmacy for direction. She reported the Levothyroxine had likely been administered with the Calcium and Ferrous Sulfate for the past three days as they were documented as administered at the same time on the MAR. She reported she would have expected staff persons preparing the medication to have caught the label precaution.

Review of the May 21, 2024: Medication: Administration Including Scheduling and Medications Aides policy identified the Six Rights of medication administration were to be followed by all staff administering medications to residents. Scheduling of medication administration was to be scheduled to avoid potential significant medication interactions identified as with food, or other medications. The administration procedure identified to review the MAR for medications that were due for administration, follow the Six Rights

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) Right medication; 2.) right dose; 3) right resident; 4.) right route; 5.) right time; 6.) right documentation. Perform three checks: Read the label on the container/card and compare with the [DATE].) when removing from the cart; 2.) placing the medication in the cup; 3.) just before administering the medication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336 Based on interview and record review the facility failed to complete an Abnormal Involuntary Movement Scale (AIMS) for 1 of 1 resident (R12) reviewed for unnecessary medications per facility policy and procedure. Findings include: R12 was admitted [DATE] and had a diagnosis of dementia, depression, and heart failure. He had taken Seroquel (treats schizophrenia, bipolar disorder, and manic disorder) 25 milligrams (mg) at bedtime for dementia with a start date of 1/19/24 and sertraline (treats depression) 100 mg daily for depression with a start date of 9/16/23. R12's, 12/11/24 Significant change Minimum Data Set (MDS) identified he was cognitively impaired had little interest or pleasure in doing things and had felt down, depressed, or hopeless never to 1 day. R12 had taken antipsychotics and antidepressants on a scheduled basis. R12's, medical record identified an initial AIMS (test used to assess abnormal movements in people with on anti-psychotic or psychotropic medication) in September 2023. The medical record had lacked evidence of a bi-annual or annual AIMS assessment thereafter. R12's current, undated care plan identified R12 had used psychotropic medication related to dementia and depression. Interventions were for staff to consult with pharmacy, health care provider to consider dosage reduction, discuss with health care provider for ongoing need of use of medications, educate resident/family about risks, benefits, side effects and toxic symptoms of medication, and would monitor target behaviors such as refusal of cares and lack of self-awareness related to safety. During interview on 1/13/25 at 4:34 p.m., with the interim director of nursing (IDON) identified she expected staff to perform updated AIMS assessment for residents taking psychotropic medication according to the facility policy, as indicated. Review of December 2024 Psychotropic Medications- Rehab/Skilled policy identified staff were to complete an initial antipsychotic medication assessment and an AIMS assessment to screen for signs or symptoms of potential Tardive Dyskinesia (abnormal movements caused by psychotropic medication). In addition, staff were to complete the AIMS assessment every 6 months. If a change was identified in a resident from the previous AIMS assessment the registered nurse would inform the primary care physician and family/legal guardian representative and would document the notification in the resident medical record.

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34083

Based on observation, interview, and document review the facility failed to ensure 5 of 5 residents (R4, R15, R18, R32 and R91's) discontinued controlled narcotic medications were not stored with in-use medications in 2 of 2 medication carts.

Findings include:

Observation and Medication Administration Record (MAR) on [DATE] at 6:03 p.m., with registered nurse (RN)-D and licensed practical nurse (LPN)-B during a controlled narcotic medication count of 2 of 2 medication carts identified:

1) R4 had 1 box of 5 Fentanyl 25 mcg patches stored in the East medication cart, which RN-D identified had been sent in error by the pharmacy and received by the facility on [DATE] or [DATE]. The pharmacy had been notified on [DATE] when the error had been discovered and confirmed none of the incorrect patches had been administered. She reported the patches had been left in the medication cart until they could be destroyed.

2) R18 had 2 unopened blister packs each containing 30 tablets of Lorazepam 0.5 milligrams (MG) which RN-D confirmed were discontinued on [DATE].

3) R19's medical record identified he was deceased on [DATE] and his medications remained in the in-use narcotic box identified as: Morphine Sulfate 100 mg/5 milliliters (ml) unopened 15 ml bottle, 1 opened bottle of Morphine Sulfate 100 mg/5 ml with 8.75 ml remaining in the bottle, 2 blister packs of Lorazepam 0.5 mg tablets 1 blister package containing 1 tablet and 1 pack containing 30 tablets. The medical record identified the Lorazepam had been discontinued on [DATE].

4) R32 had 2 unopened blister packs of Lorazepam 0.5 mg tablets with each blister package containing 30 tablets. The medical record identified this medication was discontinued on [DATE].

5) R91 had 2 blister packs of Oxycodone HCl 5 mg tablets 1 blister pack contained 12 tablets, and 1 pack contained 30 tablets. The record identified the medication had been discontinued on [DATE].

Interview on [DATE] at 6:25 p.m. with RN-D and LPN-B identified when a controlled medication was changed or discontinued the medication continued to be counted with each narcotic count and stored in the narcotic boxes located on the medication carts, until 2 licensed staff had time to destroy them. Both nurses reported they were not aware discontinued medication was not to be stored with in-use medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 6:33 p.m. with the interim director of nursing (DON) identified she was not aware discontinued controlled medications were being stored with in-use medications. When a controlled medication was discontinued or changed resulting in the need for destruction, it should be removed from the in-use medications and stored in a separate secured location until destroyed. The medications would still need to be counted with each narcotic count until destruction with appropriate documentation was completed. Interview on [DATE] at 4:25 p.m. with the consultant pharmacist confirmed discontinued controlled medications should not be commingled with in-use medications due to the potential for error or diversion. She was not aware this was occurring and would investigate the situation further with her next visit to the facility on [DATE]. Review of the [DATE], Policy Medication Administration failed to contain documentation on controlled medication storage, and no additional policies were provided by the end of the survey period.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49336 Based on observation, interview, and document review, the facility failed to follow appropriate infection control practices for 1 of 2 residents (R2) indwelling catheter. Findings include: R2's, 12/11/24 Significant Change Minimum Data Set (MDS) assessment, identified she was cognitively intact and had a diagnosis of neurogenic bladder (bladder problems related to injury or disease), which required a urinary draining bag (tube that collects urine from the bladder). R2's, current, undated care plan identified interventions for staff to monitor, record, and report to the health care provider signs and symptoms of urinary tract infection (UTI), such as pain, burning, blood-tinged, foul-smelling urine, fever, altered mental status, change in behaviors, and change in eating patterns. During initial interview and observation on 1/12/25 at 11:46 a.m., with registered nurse (RN)-A and R2 identified R2 was seated in her recliner and the urinary drainage bag was hung from the trash can over a gray basin that was placed on the floor next to R2's recliner. R2 stated she and nursing staff hung her urinary drainage bag from the trash can to keep the catheter tubing below her bladder. Observation on 1/12/25 at 1:13 p.m., as the interim director of nursing (IDON) wheeled R2 to her room and assisted R2 with transfer to her recliner. When the IDON exited the room, R2's urinary drainage bag was hung from the trash can. Interview on 1/13/25 at 10:40 a.m., with nursing assistant (NA)-A reported R2 transferred her urinary drainage bag from her walker and hung it from the trash can. She informed R2 it was not a good idea for the urinary drainage bag to be hung from the trash can and offered to place the urinary drainage bag to another location. During interview on 1/13/25 at 10:43 a.m., with registered nurse (RN)-A she reported R2 was independent with her care needs and would need reinforcement and education of properly securing her urinary drainage bag to prevent contamination. Observation and interview on 1/13/25 at 4:14 p.m., with RN-B in attendance, noted R2's catheter bag was again hung from the trash can, upon entering R2's room. She confirmed it was not an acceptable infection control practice and would need to re-educate R2 of appropriate techniques to position her urinary drainage bag when in use. Observation and interview on 1/13/25 at 4:16 p.m., trained medication aide (TMA)-A in attendance, noted R2's urinary drainage bag was again hung from the trash can. TMA-A stated R2's urinary drainage bag that was hung from the trash can was not the appropriate place for the catheter bag and stated R2 had limited options on where she could hang her urinary drainage bag when seated in her recliner. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/13/25 at 4:34 p.m., with the IDON she stated nursing staff and R2 would need further education on infection control practices related to urinary drainage bag placement to prevent complications and reduce infection control risks. Review of July 2024 Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen-AL, R/S & LTC policy identified the facility staff would maintain and properly secure catheters. Secondly, closed connection systems, such as, indwelling catheters that were found to be contaminated by inappropriate infection control practices were to be replaced, immediately. In addition, the facility staff would educate and document residents and/or family of the risk and benefits of indwelling catheters use.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 49336 Based on interview and document review the facility failed to ensure 1 of 8 staff received newly hired staff nursing assistant (NA-D) received initial training on Alzheimer's disease or related disorders, assistance with activities of daily living (ADL), problem solving with challenging behaviors, and communication skills. This had the potential to affect all the residents in the facility. Findings include: Review of the employee file for nursing assistant (NA)-D had a hire date of 10/29/24. Interview on 1/13/25 at 4:41 p.m., with interim director of nursing would expect Alzheimer/Dementia training to be completed for all staff who are taking care of vulnerable adults at the facility. Review of August 2024 Facility Assessment identified the facility would train staff on Dementia and behavioral health during general orientation. In addition, the facility would provide annual staff in-services pertaining to Federal and State requirements related to continuity of care and resident safety. Copy of NA-D training policy was requested and not provided during survey.