

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245593	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - St James		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 South Second Street St James, MN 56081	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify the resident representative and the medical provider following a fall with potential injury for 1 of 1 resident (R132) reviewed for notification of change.</p> <p>Findings include:</p> <p>R132's face sheet printed on 6/10/25, included diagnoses of dementia with agitation, psychosis and anxiety, and delusional disorder.</p> <p>R132's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R132 had severe cognitive impairment, unclear speech, was sometimes understood and could sometimes understand. R132 had frequent behaviors such as pacing and rummaging. R132 required supervision, partial assistance or was dependent on staff for activities of daily living. R132 could walk independently.</p> <p>R132's physician orders dated 2/27/25, indicated hospice order for evaluation and treat.</p> <p>R132's nursing order dated 2/6/25, indicated have staff walk R132 at least twice a shift every 4 hours related to dementia.</p> <p>R132's care plan included focus areas of: risk for falls related to incontinence, psychoactive drug use and wandering dated 12/3/23; terminal prognosis due to dementia and on hospice care dated 1/19/24, and impaired cognition related to dementia, revised date 11/6/24.</p> <p>During a telephone interview on 5/22/25 at 2:52 p.m. family member (FM)-C stated R132 fell the evening of 3/5/25, and FM-C was not notified. R132 fell again the morning of 3/6/25, and FM-C was notified. The nurse who called to inform FM-C told her this had been R132's second fall in two days. That was how FM-C learned of the first fall on 3/5/25. FM-C stated R132 had been in a lot of pain in his left leg after the falls. R132 subsequently passed away on 3/9/25, four days after the first fall.</p> <p>During a telephone interview on 5/28/25 at 6:51 p.m., FM-C stated no one had asked her, with R132's increasing leg pain, if she would want R132 to have an x-ray to determine if there had been a fracture. FM-C added, they said they contacted hospice and would monitor him because he couldn't walk and would give him morphine (a narcotic pain medication).</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: 245593	Facility ID: 245593 If continuation sheet Page 1 of 26

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Progress note dated 3/5/25 at 2:03 a.m., indicated R132 was found on floor shortly after power went out (due to city power outage). Possibility of resident falling due to having no light. Tried assessing vitals and neuros (neurological status) while resident was on ground, but resident kept trying to get up. Resident was moved from floor to bed via Hoyer (mechanical lift) with help of nursing assistant (NA). Resident did wince when left leg was touched.</p> <p>Progress note dated 3/5/25 at 2:09 a.m., indicated the administrator and DON (director of nursing) notified through text message. Information sheet filled out for certified nurse practitioner (CNP)-D. Resident's family will be notified during business hours. (There was no follow up documentation indicating FM-C was notified).</p> <p>Progress note dated 3/5/25 at 9:05 p.m., indicated hospice was called and updated on fall from late last night. Updated on use of morphine for pain/discomfort. Unable to bear weight on LLE (left lower extremity), required assist of two to transfer into bed.</p> <p>Hospice progress note dated 3/5/25 (no time noted), by hospice triage registered nurse (RN) indicated: Patient fell. Having some hip pain. Advised hospice recommends least invasive treatment and to defer to patients POA (power of attorney) for course of treatment.</p> <p>Progress note dated 3/6/25 at 9:10 a.m., indicated R132 was found on floor sitting beside bed, moaning of pain in left hip area; resident grabbed hip.</p> <p>Progress note dated 3/6/25 at 5:09 p.m., indicated hospice was notified to update them that resident is still not putting any weight on LLE. Resident says he's in pain, but that's the only information you can get out of resident. Hospice said to keep up with morphine PRN (as needed) and they will be sending out a nurse to come see resident.</p> <p>Hospice progress note dated 3/6/2025 (no time noted), indicated (RN)-D who was a hospice nurse, was at facility for a post-fall visit. Facility nurse reports R132 had a fall last night at 9:00 p.m., that was unwitnessed. After fall, according to [hospice] triage, it was reported R132 was having trouble bearing weight and having right lower extremity pain and was given prn morphine. R132 was not transported to the hospital according to facility nurse. Facility nurse reports R132 was requiring a two-person transfer after fall. Facility nurse reports R132 had another fall this morning after breakfast that was a non-witnessed fall. R132 was helped back to bed, given morphine, which was effective and prn O2 (oxygen) was applied due to saturations in the 60's. R132 was observed resting in bed with O2 on via nasal cannula at 2 liters per minute. R132 was keeping the O2 on which was out of the ordinary. R132 was not responsive to voice or touch which was his baseline when sleeping. R132 continued to have full body involuntary movements where his whole body would twitch. R132 appeared very comfortable. Spoke to FM-C who reports she was not aware of the fall last night until just now; she would like to schedule morphine at this time to try to keep him comfortable and perhaps dissuade R132 from trying to get up again today.</p> <p>Progress note dated 3/6/25 11:51 a.m., indicated IDT (interdisciplinary team) met to review incident of R132 trying to ambulate in the dark and fell. Will get R132 a night light that has battery powered back up for if the lights go out.</p> <p>Progress note dated 3/6/25 at 9:01 p.m., indicated staff not able to carry out nursing order to walk R132 at least twice a shift due to recent fall as R132 not unable to bear weight on left leg.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Progress note dated 3/7/25 dated 12:32 a.m., indicated staff not able to carry out nursing order to walk R132 at least twice a shift due to no weight bearing on left hip.</p> <p>Progress note dated 3/8/25 at 8:20 p.m., indicated R132 had remained in bed throughout the shift. Knees were bent, opening slowly, and then quickly closed continuously. Has received scheduled and prn MS (morphine) and prn Ativan (anti-anxiety medication). Receiving O2 via a mask due to mouth breathing. Has not exited his bed.</p> <p>Progress note dated 3/9/25 at 5:00 a.m., indicated R132's condition was poor. In the dying process. MS (morphine) and lorazepam (anti-anxiety medication) given as ordered but has difficulty swallowing. Comfort measures done. Mouth care. Has been incontinent of urine several times. Turned and repositioned for comfort.</p> <p>Progress note dated 3/9/25 at 8:02 a.m., and identified as a late entry indicated spoke to FM-C about R132's condition and if they would want to come sit with him as his condition was deteriorating more quickly.</p> <p>Hospice progress note dated 3/9/25, (no time noted), family present at bedside. Facility reports pt has not eaten since fall on Tuesday (3/6/25) and has only tried to get out of bed once. Observed nonresponsive in bed with oxygen on. Mouth breathing. No periods of apnea (temporary cessation of breathing) noted. Respirations are somewhat agonal (last gasps). Discussed with family signs and symptoms of end of life. They appear to be coping well and prepared for this. Pt appears comfortable and not in distress. Discussed protocol with facility for when pt passes.</p> <p>Progress note dated 3/9/25 at 8:05 a.m., and identified as a late entry indicated hospice was notified of residents failing state of health and will come to assess resident condition. Resident passed after hospice nurse left, and she was to be notified of his passing to call the funeral home and details.</p> <p>Progress note dated 3/9/25 at 13:51 p.m., indicated on-call nurse practitioner was updated on death and received order to release residents body.</p> <p>During an interview on 5/29/25 at 7:39 a.m., registered nurse (RN)-A stated R132 had pain after his falls and thought he had an x-ray. While looking for documentation in the EMR (electronic medical record) for an x-ray, RN-A found a fax communication dated 3/6/25 at 10:30 a.m., from the facility to certified nurse practitioner (CNP)-D which indicated R132 was found on the floor at 9:10 a.m. Left hip pain and moaning. Vital signs within normal limits. Skin assessment done. Oxygen applied. CNP-D informed the facility to follow up if problems weight bearing and increased pain. RN-A did not know if or how that order would have been shared with all nurses if they had not seen the fax. No order had been entered into the EMR to prompt nurses to monitor R132's weight bearing and pain, and to notify CNP-D.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/29/25 at 9:14 a.m., CNP-D reviewed the fax communication dated 3/6/25 at 10:30 a. m. CNP-D states she did not recall being informed R132 was having increased pain and problems with weight bearing as she had ordered staff to do. CNP-D stated had staff informed her R132 had not been bearing weight and had increased pain, she would have ordered an x-ray, then talked to the family to ask if they agreed. If they agreed, the x-ray was ordered, if they did not want an x-ray, the order would be canceled. CNP-D stated it would have at least initiated a conversation. CNP-D acknowledge the fall, and potentially undetected fracture could have hastened his death, stated, Yes, it could have contributed to it. R132 was very thin and had no cushion, so there was a high chance he had a fracture.</p> <p>During an interview on 5/29/25 at 9:53 a.m., the director of nursing (DON) and the administrator were asked about the following events:</p> <ol style="list-style-type: none"> 1. Was 132's family notified of the fall on 3/5/25, at approximately 2:00 a.m.? Progress notes dated Monday 3/5/25, at 2:09 a.m., indicated, residents family will be notified during business hours. There was no documentation in the EMR to indicate family was notified. The DON stated staff usually notified family no matter what time of day an event occurred. The administrator stated FM-C had been informed after the second fall. 2. Did the nursing staff follow CNP-D order to follow up with her if R132 had problems weight bearing and increased pain? The DON stated the staff would have notified hospice. The DON was asked if staff would call hospice even though the order came from CNP-D. The DON stated she found it hard to believe staff did not follow up with CNP-D and stated she would look for that documentation. The DON and administrator stated they were unaware R132 had been having increasing difficulty bearing weight and having increased pain. 3. FM-C was not given opportunity to decide if R132 should have an x-ray to determine if a fracture occurred after the falls. The DON stated FM-C had been given that opportunity. The DON was asked for that documentation. <p>The DON provided a document titled Nursing Home Scheduling, which was a form prepped by the facility to indicate names of residents who should be seen during a provider visit. This document was dated 3/6/25, and did not include R132. The DON acknowledged this would have been an opportunity to request CNP-D to see R132. The DON did not know why R132 had not been added to this schedule.</p> <p>An email received from the DON dated 5/30/25 at 2:56 p.m., indicated no documentation had been found indicating FM-C has been notified of R132's fall on 3/5/25. No documentation was found indicating CNP-D had been notified of R132's problems bearing weight and his increasing pain.</p> <p>Facility Notification Of Change policy dated 12/23/24, indicated a facility must immediately inform the resident, consult with the resident ' s physician and notify, consistent with his or her authority, the resident representative(s) when there is: 1) An accident involving the resident which results in injury and has the potential for requiring physician intervention. 2) A significant change in the resident ' s physical, mental or psychosocial status. 3) A need to alter treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure a comprehensive care plan was developed and maintained for 1 of 1 resident (R2) reviewed reviewed for constipation.</p> <p>Findings include:</p> <p>R2's diagnosis report printed on 5/29/25, included dementia, and encounter for palliative (comfort) care.</p> <p>R2's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severely impaired cognition, unclear speech, rarely understands or is understood and has severely impaired cognitive skills for daily decision making. R2 was dependent on staff for all activities of daily living (ADL's). R2 was receiving hospice services.</p> <p>R2's physician orders included Senna-S (laxative) tablet 8.6-50 mg (milligrams) dated 7/17/24; Give 1 tablet by mouth one time a day; may give two tablets every 24 hours as needed for constipation. May give up to twice daily as needed. Contact provider/practitioner if there are 3 days without a significant BM.</p> <p>Additional physician orders dated 9/10/24, included dulcolax suppository 10 mg every 6 hours as needed for constipation. Contact provider/practitioner if there are three days without a significant BM.</p> <p>An order from Hospice dated 5/11/25, included give dulcolax suppository every other day.</p> <p>R2's Care Area assessment dated [DATE], included urinary incontinence but did not include bowel issues.</p> <p>R2's care plan with revised date of 1/1/25, did not include care plan for incontinence of bowel or bladder or constipation or bowel issues. The care plan did include multiple other care areas including hospice, opioid use and pain management.</p> <p>On interview 5/27/25 at 2:00 p.m., family member (FM)-B stated R2 ended up in the emergency room (ER) because she hadn't pooped in days. FM-B stated on her daily visit, she knew her mom was uncomfortable by her facial grimacing and staff told her she hadn't had a BM in multiple days.</p> <p>Record review identified R2 had no documented BM for 4/1/25 to 4/5/25; 4/8/25 to 4/18/25; 4/19/25 to 4/29/25; 4/30/25 to 5/5/25, 5/8/25 to 5/13/25; 5/19/25 to 5/22/25; 5/23/25 to 6/1/25.</p> <p>During an observation 5/28/25 at 9:39 a.m., R2 was transferred from her Broda (positioning) chair to her bed with use of lift and nursing assistant (NA)-A and NA-E. R2's incontinence pad was wet with no BM. Staff changed the pad, performed perineal care, placed a new pad and positioned R2 in the bed. R2 was non verbal. NA-A and NA-E indicated R2 can not verbalize pain but you can tell by her facial expressions and change in behavior when she is in pain and they report that to the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On interview 5/28/25 at 1:35 p.m., registered nurse (RN)-A stated each resident is different on the amount of days they can go without a BM. RN-A stated R2 should have a plan of care to address her constipation issues especially since being on opioids which can cause constipation.</p> <p>On interview 5/29/25 at 11:45 a.m., the director of nursing (DON) confirmed the care plan lacked a plan to address R2's constipation issues and she should have one.</p> <p>Facility Bowel and Bladder: Evaluation, Assessment, Toileting Programs policy dated 5/7/25, included:</p> <ul style="list-style-type: none"> - Care plan interventions should be individualized based on the CAA assessment and modified as appropriate based <p>on an assessment/evaluation of the resident ' s response to the interventions and success with attaining/maintaining bowel continence. Any alteration of elements of the program should be made one at a time. Examples that may be tried for a week include:</p> <ul style="list-style-type: none"> &middot; Suppository frequency &middot; Number of suppositories &middot; Diet &middot; Fluid volume &middot; Activity &middot; Medication <p>-Modify one element of the program as suggested and add to care plan.</p> <p>-Use focuses/goals/interventions from the the EMR library to care plan bowel function/status interventions.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility Comprehensive Care Plan and Care Conferences policy dated 1/31/25, included:</p> <p>Formulating the Care Plan</p> <p>- The care plan is driven by identified resident issues/conditions and their unique characteristics, strengths and needs. When implemented in accordance with standards of good clinical practice, the care plan becomes a powerful, practical tool representing the best approach to providing quality of care and quality of life.</p> <p>-The focus includes:</p> <p>The identified problem or strength.</p> <p>What the problem is related to (r/t) (what you feel is contributing to the problem). This usually is a diagnosis, event or occurrence.</p> <p>What the problem is evidenced by (e/b) (what you see or hear the resident doing that tells you there is a problem, need or concern). Use language easily understood by all employees.</p> <p>Note: If the focus is a potential for, the care plan may not need an evidenced by statement.</p> <p>-Problems/needs/concerns/strengths may be combined on the care plan as long as individual needs are addressed.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to have an admission or quarterly care conference or invite and/or involve the resident and/or family representative to participate in their quarterly care conference for 3 of 3 residents (R26, R3, and R4) reviewed for care planning.</p> <p>Findings include:</p> <p>R26's admission Record indicated admission to the facility on 1/9/25.</p> <p>R26's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R26 was cognitively intact, required substantial/maximal assistance with walking, toileting, and transfers. Diagnosis included osteomyelitis (bone infection), ileostomy status (surgical procedure that creates an opening in the abdomen for the ileum (the last part of the small intestine) to exit, allowing waste to be collected in an external pouch), sepsis (blood infection), and cystitis (inflammation of the bladder caused by urinary tract infection).</p> <p>R26's care plan dated 2/25/25 and last revised 5/20/25, included multiple care areas related to activities of daily living (ADLs), pain management and disease processes.</p> <p>R26's electronic medical record (EMR) did not include a care conference meeting note or that R26 was included in development and revisions of the plan of care.</p> <p>On interview 5/27/25 at 11:28 a.m., R26 stated she has not had any care conference meetings since being at the facility nor have they asked about her input for her care plan. R26 stated she is going home at the end of the week.</p> <p>On interview 5/28/25 at 1:53 P.M., R26 confirmed she has not had any care conference meetings since being at facility and was not involved in her care plan development. R26 stated she was surprised she hasn't had one as she was always involved with her mother's care conferences when she was a resident.</p> <p>On interview 5/28/25 at 2:16 p.m., social service director (SSD)-A confirmed R26 has not had a care conference since she has been at the facility. SSD-A stated R26 should have had at least one care conference but added she had met with the resident and a family member but that did not include other team members.</p> <p>R3's admission Record indicated admission to the facility on 7/2/24, with diagnoses including heart failure, dementia and major depressive disorder.</p> <p>R3's quarterly MDS dated [DATE], indicated moderate cognitive impairment, but usually understands and is understood. R26 had no behaviors, is on scheduled pain medications rating pain at 7 on scale of 1-10, and is on medications including opioid, antidepressant, anticonvulsant, antiplatelet and diuretic. R3 also has had one fall and requires partial to moderate assist with activities of daily living.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On interview 5/27/25 at 1:38 p.m., R3, using interpreter service, stated they have never invited him to a care conference and he has not had any input into his plan of care at the facility since he has been here.</p> <p>Review of the electronic medical record (EMR) included a Care Conference on 4/16/25, which indicated 2 staff attended and R3 was invited but chose not to attend. The EMR lacked evidence of other care conferences.</p> <p>On interview 5/28/25 at 2:16 p.m., SSD-A stated R3 had a care conference initially but none since that time. SSD-A stated the facility had multiple people missing that generally attend care conferences so were not able to get the care conferences completed and were aware they were not in compliance.</p> <p>On interview 5/29/25 at 11:29 a.m., the director of nursing (DON) stated care conferences should happen within the first 21 days the resident is at the facility and then quarterly after that.</p> <p>R4's face sheet received on 5/29/25, included diagnoses of heart failure, high blood pressure, and chronic kidney disease.</p> <p>R4's quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R4 was independent or required supervision with ADLs.</p> <p>R4's care plan initiated 1/27/25, included multiple focus areas, goals and interventions. The care plan did not include care conferences.</p> <p>R4's care conference progress note dated 5/14/25 at 10:43 a.m., indicated staff and family member (FM)-A were present. Nursing reported on health and went over the medication. Increase weight was discussed. Family wants her treated only at the nursing home and not the hospital. Dietary reported on intake and weight. Code statue was reviewed, and remains a DNR (do not resuscitate). Family was given a copy of the care plan. Social worker reported on assessments and participation [in activities].</p> <p>During an interview on 5/27/25 at 3:19 p.m., R4 and FM-A stated since R4's admission in January (1/21/25), R4 had only one care conference and that was a couple of weeks ago. FM-A stated she was aware the social worker had been out of work for a while.</p> <p>During an interview on 5/28/25 at 3:27 p.m., SSD-A stated she was responsible for arranging and facilitating care conferences. SSD-A stated on 1/29/25, she had been getting ready to conduct multiple resident care conferences, including R4's when she became incapacitated and the care conferences that were scheduled that day were not done nor rescheduled.</p> <p>During an interview on 5/29/25 at 10:39 a.m., the DON and administrator were informed R4 had not had an initial care conference after admission in January due to SSD-A not being able to conduct them on 1/29/25. Informed R4's first and only care conference was on 5/14/25. The administrator thought the 1/29/25, care conferences had been rescheduled and would look for documentation.</p> <p>An email from the administrator dated 5/29/25 at 11:23 a.m., indicated unable to find documentation of an initial care conference, or talking with R4's family in the beginning of her stay.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility Comprehensive Care Plan and Care Conferences policy dated 1/31/25, indicated the purpose was to provide an ongoing method of assessing, implementing, evaluating and updating the resident's care plan to help maintain the resident's highest practicable level of function. The social worker would establish the time and place to hold the care conference. Residents and their representative would be invited at least two weeks in advance of the care conference. If resident and/or representative were not invited to the care conference, an explanation would be included in the medical record. Residents and representatives would be informed of the right to request meetings, request revisions to the care plan and to be informed in advance of changes to the care plan. Residents had the right to see the care plan and to sign the care plan after significant changes were made. If the resident requested to sign the care plan, print a signature page and the care plan from PCC (Point Click Care, electronic medical record). The social worker would function as the facilitator during the care conference, keeping the meeting on task and making certain that residents and/or their representatives had an opportunity to voice any concerns. The social worker would facilitate the discussion of the resident's care plan and summarize the changes since the last interdisciplinary team review.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based of observation, interview, and record review, the facility failed to assist with personal hygiene (oral care, shaving) as directed by the plan of care for 2 of 2 resident (R12, R25) reviewed for activities of daily living (ADLs).</p> <p>Findings include:</p> <p>R12's face sheet provided on 5/29/25, included diagnoses of chronic kidney disease and high blood pressure.</p> <p>R12's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R12 had intact cognition, clear speech, could understand and be understood. R12 required assistance with most ADLs. For oral care, the MDS indicated: set up, clean-up assistance; helper sets up and cleans up; resident completes activity.</p> <p>R12's care plan dated 4/11/25, indicated R12 had an ADL self-care performance deficient related to recent hospitalization as evidenced by weakness and needing rehabilitation. R12's care plan did not include assisting R12 with oral care on a routine and regular basis.</p> <p>R12's Kardex (a reference point in the electronic medical record for nursing staff that provides a summary of a residents care and serves as a documentation tool) printed on 5/29/25, indicated in a section titled AM/PM Care: adjust provision of ADLs to compensate for R12's changing abilities. Encourage participation to the extent R12 wishes to participate. Oral care was not specifically addressed in the Kardex.</p> <p>R12's electronic medical record (EMR), under the TASK tab, was an assignment titled Oral Care. The question staff were to document was, was oral care provided. Out of 60 opportunities in the past 30 days for R12 to be assisted with oral care (morning and evening), there was only one entry dated 5/18/25, at 8:55 p.m. , documented as refused.</p> <p>During an interview on 5/27/25 at 1:32 p.m., R12 stated, I never brush my teeth, adding he never asked staff to help him brush his teeth and they didn't ask him. R12 stated everyone was in a hurry to get residents to breakfast in the morning. R12 stated no one offered to help brush his teeth before going to bed either.</p> <p>During an observation on 5/28/25 from 9:08 a.m., to 9:30 a.m., observed nursing assistant (NA)-A provide morning cares, including assisting R12 out of bed and into the bathroom using walker, assisting R12 to sit on the toilet, switched R12's urinary drainage bag to a leg bag, changed his shirt, gave him a warm wash cloth to wash hands and face, wiped buttocks and apply a new brief, combed R12's hair and gave him his eye glasses. At 9:30 a.m., NA-A escorted R12 to the dining room via wheelchair. Oral care was not offered.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 5/28/25 at 2:10 p.m., R12 was resting in his recliner. Stated no one had helped brush his teeth, and stated he supposed he should brush his teeth. Observed tooth brush in a plastic disposable emesis basin in the cupboard in R12's bathroom. Toothbrush appeared dry; no residual water in basin.</p> <p>During an observation on 5/29/25 at 8:44 a.m., in his bathroom, observed R12's toothbrush appeared to be dry; no residual water in emesis basin.</p> <p>During an interview on 5/29/25 at 9:01 a.m., NA-B verbalized the care she provided to R12 that morning but did not verbalize oral care or brushing teeth. When asked if she assisted R12 to brush his teeth, she stated, yes. NA-B stated she dried the toothbrush with a towel so it wouldn't stain the plastic disposable emesis basin.</p> <p>During an interview on 5/29/25 at 9:05 a.m., R12 stated no one had helped him brush his teeth yet and stated he would like his teeth brushed, adding, I probably have bad breath.</p> <p>During an interview on 5/29/25 at 10:31 a.m., the director of nursing (DON) and administrator were informed of findings, including interviews, observations and document review. The administrator stated NA's had talked to her about this and told her they definitely did R12's oral care today. The DON and administrator were informed R12 was admitted on [DATE], and in the past 30 days, there had been only time where oral hygiene was documented and that was a refusal on 5/18/25. The administrator stated, that is why we tell staff they need to document.</p> <p>R25's face sheet printed 5/29/25, indicated diagnoses of chronic kidney disease, depression, morbid obesity, and diabetes mellitus type II.</p> <p>R25's quarterly MDS assessment dated [DATE], indicated intact cognition, no rejection of care, use of wheelchair, and partial/moderate assistance with personal hygiene which included shaving.</p> <p>R25's care plan dated 10/7/24, indicated ADL self-care performance deficit related to impaired mobility, pain, incontinence, and fatigue. Care plan further indicated R25 required setup assistance for personal hygiene.</p> <p>During interview and observation on 5/27/25 at 1:22 p.m., R25 had visible chin hair. R25 state she would prefer chin hair shaved and didn't like how long it was. R25 stated she could not always stand up to look in the mirror.</p> <p>During interview and observation on 5/28/25 at 3:42 p.m., R25 still had long chin hair. R25 stated she was unsure if she had a razor, and no one had offered to assist her with shaving this morning with morning cares. R25 further stated she sometimes asked staff to help her shave her chin, but they would say they were too busy. R25 stated the chin hair really bothered her.</p> <p>During interview on 5/29/25 at 9:22 a.m., NA-B stated R25 had never had a razor and she had not told a nurse because she would get busy and forget, so she had not been able to shave her. NA-B further stated she knew R25 wanted to be shaved.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 5/29/25 at 9:26 a.m., registered nurse (RN)-A stated she noticed a few days ago R25 needed her chin shaved and was going to trim it but it had slipped her mind. RN-A stated she did not know R25 did not have a razor and would have to work on getting her one.</p> <p>During interview on 5/29/25 at 10:19 a.m., DON stated she was unaware R25 had long chin hair or that she did not have a razor in her room. DON stated she would expect R25 to be shaved if that was her preference.</p> <p>Facility Activities of Daily Living policy dated 12/23/24, indicated the purpose was to provide residents with appropriate treatment and services to maintain or improve abilities in ADLs for the well-being of mind, body, and soul. Any resident who was unable to carry out ADLs would receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. ADLs were those necessary tasks conducted in the normal course of a resident's daily life. Included in these are the following:</p> <p>1.</p> <p>General Personal, Daily Hygiene/Grooming: Care of hair, hands, face, shaving, applying makeup, skin, nails, and oral care</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to implement bowel movement (BM) orders or notify the provider for 1 of 1 resident (R2) reviewed for constipation. In addition the facility failed to administer eye drops according to professional standards of practice for 2 of 3 residents (R7, R133) reviewed for medication administration. In addition, the facility failed to comprehensively assess and monitor significant bruising and a contusion for 1 of 1 resident (R4) reviewed for non-pressure skin conditions. Further, the facility failed to perform quality controls on glucometers used to assess resident blood glucose for 1 of 3 residents (R7) reviewed for insulin.</p> <p>Findings include:</p> <p>Constipation</p> <p>R2's diagnosis report printed on 5/29/25, included dementia, and encounter for palliative (comfort) care.</p> <p>R2's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severely impaired cognition, unclear speech, rarely understands or is understood and has severely impaired cognitive skills for daily decision making. R2 was dependent on staff for all activities of daily living (ADL's). R2 was receiving hospice services.</p> <p>R2's physician orders included Senna-S (laxative) tablet 8.6-50 mg (milligrams) dated 7/17/24; Give 1 tablet by mouth one time a day; may give two tablets every 24 hours as needed for constipation. May give up to twice daily as needed. Contact provider/practitioner if there are 3 days without a significant BM.</p> <p>Additional physician orders dated 9/10/24, included dulcolax (laxative) suppository 10 mg every 6 hours as needed for constipation. Contact provider/practitioner if there are three days without a significant BM.</p> <p>An order from Hospice dated 5/11/25, included give dulcolax suppository every other day.</p> <p>R2's Care Area assessment dated [DATE], did include urinary incontinence but did not include bowel issues.</p> <p>R2's care plan with revised date of 1/1/25, did not include care plan for constipation or bowel issues.</p> <p>On interview 5/27/25 at 2:00 p.m., family member (FM)-B stated R2 ended up in the emergency room (ER) because she hadn't pooped in days. FM-B stated the ER didn't do anything because R2 is on hospice services. FM-B stated on her daily visit, she knew her mom was uncomfortable by her facial grimacing and staff told her she hadn't had a BM in multiple days.</p> <p>Record review identified R2 had no documented BM for: 4/1/25 to 4/5/25; 4/8/25 to 4/18/25; 4/19/25 to 4/29/25; 4/30/25 to 5/5/25, 5/8/25 to 5/13/25; 5/19/25 to 5/22/25; 5/23/25 to 6/1/25.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A physician visit dated 5/2/25 at 10:30 a.m., included no acute concerns or complaints. Bowel status good.</p> <p>R2's medication administration record (MAR) indicated Senna-S tablet 8.6-50 mg was given 1 tablet by mouth one time a day April 1-30/2025 and May 1-31/25. A dulcolax suppository 10 mg was not given in April 2025. May 2025 a dulcolax suppository was given on 5/5, 5/10, 5/19 and 5/27. Senna-S tablet 8.6-50 mg give 2 tablets by mouth every 24 hours as needed up to twice daily was not administered for April or May 2025.</p> <p>During an observation 5/28/25 at 9:39 a.m., R2 was transferred from her Broda (positioning) chair to her bed with use of lift and nursing assistant (NA)-A and NA-E. R2's incontinence pad was wet with no BM. Staff changed the pad, performed perineal care, placed a new pad and positioned R2 in the bed. R2 was non verbal. NA-A and NA-E indicated R2 has had issues with having BM's and can not verbalize pain but you can tell by her facial expressions and change in behavior when she is in pain and they report that to the nurse.</p> <p>On interview 5/28/25 at 1:13 p.m., registered nurse (RN)-C, hospice nurse, stated she was not aware R2 had not a BM for 5-6 days prior to R2's ER visit. RN-C stated R2 should have a BM every other day and recently wrote an order for a duclolax suppository order for every other day. RN-C would expect if that doesn't work hospice would be notified.</p> <p>On interview 5/28/25 at 1:35 p.m., registered nurse (RN)-A stated each resident is different on the amount of days they can go without a BM. RN-A stated R2 should have a BM every other day and added R2 got stopped up on us and didn't have a BM for 3-4 days. RN-A stated night shift prints out a daily BM sheet for those who haven't had a BM in over a day. RN-A stated it is their (day shift) responsibility to check orders and give what is ordered for the resident.</p> <p>On interview 5/28/25 at 1:46 p.m., NA-E stated NA's will document in the EMR if the resident had a BM on their shift.</p> <p>On interview 5/29/25 at 11:45 a.m., the director of nursing (DON) stated after 2 days the resident should be offered milk of magnesia or whatever the orders state. For R2, the DON stated hospice added a suppository order after the ER visit to give on day 2 if no BM. The DON stated a BM report is printed out daily and residents who have not had a BM the day prior will end up on the list. Day staff are then to check orders and give whatever is ordered. The DON confirmed R2 was having difficulty with BM's and was sent to the ER as her abdomen was hard and staff could not remove any stool digitally (manually remove stool using a gloved finger). The DON reviewed the bowel movement report for R2 and confirmed R2 should not go as long as she did multiple days throughout the last 2 months without a BM and without further intervention or notification to the provider.</p> <p>A Bowel and Bladder: Evaluation, Assessment, Toileting Programs policy dated 5/7/25 included:</p> <p>Bowel Assessment</p> <ul style="list-style-type: none"> - During a 72-hour period, document bowel function in EMR. - Establish the resident ' s own familiar terms and cues used for indication of a toileting need. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- The Bowel Evaluation UDA should be completed for residents who are incontinent or who have problems with elimination, such as constipation or a history of impaction or a change in condition that affects elimination patterns.</p> <p>EYE DROP ADMINISTRATION</p> <p>R7's face sheet received on 5/29/25, included diagnosis of dry eye syndrome.</p> <p>R7's significant change MDS assessment dated [DATE], indicated R7 had moderately impaired cognition; clear speech, could understand and be understood. R7 was independent or required partial assistance or supervision with activities of daily living (ADLs).</p> <p>R7's physician order dated 3/6/23, included Refresh Optive Mega-3 Solution. Instill 1 drop in both eyes three times a day for dry eye relief.</p> <p>R7's care plan did not include a focus for dry eye syndrome.</p> <p>During an observation on 5/28/25 at 11:19 a.m., trained medication aide (TMA)-A, instilled eye drops into R7's eyes. R7 was seated in her recliner. TMA-A asked R7 to tilt her head back. TMA-A placed the tip of a single use-plastic ampule up to R7's right eye, placing the tip between the upper and lower lids and squeezed the ampule. The tip of the ampule touched R7's eye lids. TMA-A did not pull the lower lid down to place the eye drop in that pocket, nor did she attempt to assist R7 opening her eyes to ensure the drops washed over the eyeball.</p> <p>R133's face sheet received on 5/29/25, included a diagnosis of glaucoma (an eye condition that damages the optic nerve).</p> <p>R133's admission MDS assessment dated [DATE], indicated intact cognition, moderate difficulty hearing, clear speech, could understand and be understood. R133 was independent or required supervision for ADLs.</p> <p>R133's physician order dated 5/13/25, indicated pilocarpine HCL Ophthalmic Solution 2%. Instill 1 drop, right eye, three times a day for glaucoma.</p> <p>During an observation on 5/28/25 at 11:32 a.m., TMA-A instilled eye drops into R133's right eye. R133 was seated in her wheelchair. TMA-A asked R133 to tilt her head back. TMA-A placed the tip of the multi-use bottle up to R133's right eye, placing the tip between the upper and lower lids and squeezed the bottle. The tip of the bottle touched R133's eye. TMA-A did not pull down the lower lid to place the eye drop in that pocket, nor did she attempt to assist R133 opening her eyes to ensure the drops washed over the eyeball. Further, the physician order indicated one drop in the right eye and TMA-A administered two drops.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/28/25, at 11:34 a.m., while at the medication cart in the hallway, TMA was asked to verbalize the proper technique for instilling eye drops. TMA-A stated she placed the drop in the lower lid and tried not to touch tip of bottle to the eye. TMA-A stated she put the bottle of eye drops in the middle of the eye and let it drop; Sometimes it doesn't go because eye closes, so I have to give a second drop. TMA-A was informed of observations of not pulling down the lower lid and of touching the tip of the bottle to the eye. TMA-A stated where she used to work, a resident got a bruise on her eye from pulling down the lower lid, so she doesn't do that anymore. TMA-A didn't know if the facility had a policy on administering eye drops.</p> <p>During an interview on 5/29/25 at 2:30 p.m., the director of nursing (DON) was asked to verbalize the proper way to instill eye drops. The DON described the process which included ensuring the eye lids were open and drops were placed in the lower lid. The DON was informed of findings during two observations. DON was not aware of any specific training on instilling eye drops; would expect TMA-A's and nurses to know how to do that properly.</p> <p>The DON stated the facility medication administration policy did not include administration of eye drops and there were no separate policies for administration of eye drops.</p> <p>SKIN ASSESSMENT</p> <p>R4's face sheet received on 5/29/25, included diagnoses of heart failure, atrial fibrillation (irregular heart rate causing poor blood flow) and long-term use of anticoagulation (blood thinner).</p> <p>R4's quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R4's was independent or required supervision with ADLs.</p> <p>R4's physician orders dated 1/21/25, included Apixaban (blood thinner) oral tablet 2.5 mg (milligrams), give 2.5 mg by mouth two times a day for atrial fibrillation. A common side effect of a blood thinner is increased bleeding and bruising. Orders did not include monitoring of current bruises.</p> <p>R4's care plan dated 1/27/25, indicated R4 was on anticoagulant therapy related to atrial fibrillation. The nurse was to report observations of various symptoms or changes, including bruising. In addition, the care plan with revision date of 4/23/25, indicated R4 had potential impairment to skin integrity related to anticoagulation and anti-platelet treatment evidenced by easy bruising.</p> <p>R4's progress note dated 3/8/25 at 21:19 p.m., indicated she returned from the hospital via family vehicle.</p> <p>Electronic documents titled Skin Observation - V 3, were reviewed which indicated weekly skin assessments (minus two weeks) since R4's return from the hospital on 3/8/25, and her initial admission skin check. Assessments were as follows:</p> <p>--1/21/25 - admission skin check indicated no skin conditions.</p> <p>--3/8/25 and 3/9/25, were identical and indicated fading bruise to back of left hand. No measurements or characteristics were documented. Nothing documented regarding left forearm bruise.</p> <p>--3/13/25 - no documentation of bruising</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--3/20/25 - no documentation of bruising</p> <p>--3/27/25 - no documentation of bruising</p> <p>--4/3/25 - no documentation of bruising</p> <p>--4/10/25 - no documentation of bruising</p> <p>--4/17/25 - no documentation of bruising</p> <p>--4/24/25 - no documentation of bruising</p> <p>--Missed a week</p> <p>--5/8/25 - no documentation of bruising</p> <p>--Missed a week</p> <p>--5/22/25 - left hand/arm area still bruised because of old IV (intravenous infusion). No documentation of measurements or characteristics.</p> <p>--5/28/25 - no documentation of bruising</p> <p>During an interview and observation on 5/27/25 at 3:06 p.m., with R4 and family member (FM)-A, both acknowledged the significant bruise covering the entire lower left forearm and a bruise on the posterior left hand. Both stated the arm bruise was from the hospital IV but weren't sure if the hand bruise occurred in the hospital too. R4 pointed out what appeared to be a reddish contusion to the mid-lateral aspect of her left lower leg. R4 stated she hit her leg on her walker. R4 stated staff were not monitoring it and did not know if staff were aware of it. R4 wasn't sure how long it had been there - but not long.</p> <p>During an interview on 5/28/25 at 1:15 p.m., RN-A stated nursing did not monitor or measure bruising on R4's left arm and left posterior hand. RN-A stated R4 got the bruises from IV's during a hospitalization in March 2025. RN-A stated when a resident had a bruise there was no expectation for nursing to monitor them, nor a nursing order entered into the electronic medical record (EMR) to prompt nurses to monitor them. R4 did not know if a provider had been informed of R4's arm and hand bruising, nor did she think it was unusual for R4 to have the bruises two months later. Regarding new contusion to R4's mid-lateral aspect of R4's lower left leg, RN-A stated the staff just noticed it, and the nurse practitioner (NP) would look at it when she came to the facility on 5/29/25, to conduct rounds. RN-A stated the new contusion (bruise) had not been documented because she forgot. RN-A acknowledged the importance of identifying and monitoring bruising on a resident who was on an anticoagulant. Only after the new contusion was brought to RN-A's attention, was it documented on 5/28/25, at 2:10 p.m., as follows: left lower leg, 8 cm (centimeters) X 3-centimeter bruise on outside of leg. No characteristics documented, such as color, warmth, drainage, or how contusion occurred.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/29/25 at 10:39 a.m., the DON and administrator were informed of R4's bruises to arm and hand and the lack of monitoring and documentation of the bruises. The DON stated, You expect you to monitor every bruise? We would have to have a picture map of their body. The DON and administrator were also informed of the contusion to R4's leg. The DON stated she was unaware of it until RN-A informed her of it and measured it yesterday (5/28/25). The DON stated staff did skin assessments every week and would document a bruise initially, but no on-going monitoring and documentation occurred after that.</p> <p>On 5/30/25, at 3:30 p.m., the DON emailed the measurements of the arm and hand bruises:</p> <p>--Posterior left hand: 9.5 cm x 6.5 cm. R4 informed the DON she accidentally keeps hitting it on her walker.</p> <p>--Left forearm bruise: 22 cm x 14 cm. The DON indicated that bruise was from an IV during hospitalization.</p> <p>A policy on monitoring non-pressure wounds was requested and not received.</p> <p>GLUCOMETER QUALITY CONTROL</p> <p>R7's face sheet received on 5/29/25, included type 2 diabetes with hyperglycemia (high blood glucose).</p> <p>R7's significant change MDS assessment dated [DATE], indicated R7 had moderately impaired cognition; clear speech, could understand and be understood. R7 was independent or required partial assistance or supervision with activities of daily living (ADLs)</p> <p>R7's physician orders dated 4/7/25, included insulin Lantus SoloStar Solution Pen-injector 100 UNIT/ML at bedtime. Inject 17 unit subcutaneously one time a day related to type 2 diabetes with hyperglycemia. In addition, dated 7/27/25: Blood sugar checks: notify provider if glucometer reads too low or too high. (Parameters were not defined).</p> <p>R7's care plan dated 1/27/21, indicated R7 had diabetes mellitus and would have no complications through review period. Care plan dated 3/8/25, indicated R7 had diabetic therapy and insulin resistance. R7's condition would be monitored based on clinic practice guidelines or clinical standards of practice relate to Lantus (insulin).</p> <p>R7's finger-stick blood glucose measurements were obtained twice daily before meals at 5:00 a.m., and 5:00 p.m. For the month of May (5/1/25, through 5/27/25), R 7's blood glucose was obtained 54 times and indicated the following:</p> <p>&lt; 100 mg/dl (milligram per deciliter) = 1</p> <p>100 to 150 mg/dl = 16</p> <p>151 to 200 mg/dl = 19</p> <p>201 to 250 mg/dl = 7</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>251 to 300 mg/dl = 8</p> <p>301 to 350 mg/dl = 2</p> <p>**According to the Centers for Disease Control (CDC), for people with diabetes, recommend keeping blood sugar levels between 80 and 130 mg/dl before meals.</p> <p>During an interview on 5/27/25 at 2:32 p.m., R7 stated sometimes her blood sugar was high early in the morning, adding she was really concerned it was so high because early in the morning, it should be lower.</p> <p>During an interview on 5/29/25 at 7:30 a.m., RN-A stated each diabetic resident had their own glucometer and stated glucometer's were no longer calibrated, adding that wasn't done anymore. RN-A stated if there was a questionable finger-stick glucose, nurses would use another residents glucometer and check the blood sugar again. R7's brand of glucometer was Assure Platinum. RN-A was not aware of any unusual finger-stick glucose readings for R7.</p> <p>During an interview on 5/29/25 at 10:09 a.m., the DON stated the instructions for the glucometer's did not indicate they needed to be calibrated.</p> <p>During an interview on 5/29/25 at 11:45 a.m., the DON provided a binder with paper logs titled: Assure Platinum Blood Glucose Monitoring System: Quality Control Record. The DON stated she contacted a night shift nurse and learned they did perform glucometer calibration (also known as quality controls) once per month. The DON stated the night shift nurse was also responsible for restocking each residents glucometer container too (small plastic containers with lids kept in the medication cart) and which stored the residents glucometer, test strips, needles, and cotton balls. In the binder were seven paper logs dated 10/19/24, 11/5/24, 11/22/24, 12/23/24, 2/11/25, 3/11/25, 4/1/25, but none for May 2025.</p> <p>Review of the log sheets indicated the last quality control check for any resident was on 4/1/25. Since R7's blood sugar was checked twice daily and 4/1/25, was 58 days ago, 116 glucometer test strips would have been used, meaning one or two new containers of 50 test strips had to have been opened. There was no documentation of quality control checks being done.</p> <p>During an interview on 5/29/25 at 1:37 p.m., the DON was informed of the preceding findings and agreed that was accurate. The DON stated three or four residents had recently had unusually high blood sugars, but nothing had been done about it. The DON stated she thought the unusually high blood sugars were related to food, not glucometers. The DON stated they had not done any quality checks of the glucometers when they noticed resident blood sugars were unusually high. The DON stated their policy on calibration was whatever the manufacturer of the glucometer indicated. The manufacturer instructions indicated to recalibrate the glucometer when a battery is changed and/or with each new bottle of test strips or whenever there was suspicion the meter or test strips may not be functioning properly. The DON stated with unusually high finger stick glucose readings, she wouldn't think to check the glucometers. The DON stated she did not know why quality controls had not been performed in April or May.</p> <p>Inside the binder indicated the following undated instructions for when to perform a control solution test:</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ol style="list-style-type: none"> 1. Before testing with the Assure Platinum System for the first time. 2. When you open a new bottle of test strips. 3. Whenever you suspect the meter or test strips may not be functioning properly. 4. If test results appear to be abnormally high or low or are not consistent with clinical symptoms. 5. The test strip bottle had been left open, or had been exposed to light, temperatures below 39 degrees Fahrenheit or above 80 degrees F, or humidity over 80%. 6. To check your technique. 7. When the Assure Platinum Meter had been dropped or stored below 32 degrees F or above 122 degrees F. 8. Each time the batteries are changed. <p>Facility Blood Glucose Monitoring, Disinfecting and Cleaning policy dated 9/25/24, indicated one of the purposes of the policy was to perform quality control testing on the testing instrument. All locations would have a current Clinical Laboratory Improvement Amendments (CLIA) waiver. Quality control tests to ensure calibration and techniques will be performed and documented on each glucose-testing instrument once a day or as directed by the manufacturer. These quality control tests will be conducted by running samples with known glucose readings to see if the readings obtained during the quality control tests are the same as the known readings. These identified control or standard samples are obtained from the manufacturer of the instrument. Each nurse who conducts glucose testing will have on file documentation that they have had annual in-service training on the technique and precautions required to perform the test. General procedures included: Perform quality control tests once a day or as directed by the manufacturer. Document results in appropriate log. Follow the manufacturer ' s instructions for the specific device for performing the test, doing instrument calibration and the type of preventive maintenance and frequency. Log this preventive maintenance regarding each glucose meter. Glucose testing, if required by state regulations, should be included in the QAPI Program through correlation studies (having the laboratory draw a sample at the same time a finger stick is done and comparing the results). If the results are not consistently accurate, enrollment in proficiency testing may be required. If the blood sugars have been stable, other alternate sites that may be used include the thumb, palm, forearm, and thigh. Note that it is often difficult to get blood from these areas and the lancing device may need to be adjusted.</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** Based on observation, interview and document review, the facility failed to provide services to maintain and/or prevent loss of range of motion (ROM) for 1 of 2 residents (R7) reviewed for limited range of motion.</p> <p>Findings include:</p> <p>R7's face sheet received on 5/29/25, included diagnoses of chronic kidney disease, diabetes, dementia, Alzheimer's disease, muscle weakness and difficulty walking.</p> <p>R7's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R7 had moderately impaired cognition; clear speech, could understand and be understood. R7 was independent or required partial assistance or supervision with activities of daily living (ADLs). R7 used a walker or wheelchair for mobility. R7 was able to walk 10 feet with supervision, but 50-100 feet was not attempted.</p> <p>R7's current physician orders printed on 5/29/25, did not include an order for physical therapy evaluation and treat.</p> <p>R7's care plan with revision date of 1/13/25, indicated R7 had a need for restorative intervention related to activity intolerance, limited ROM, limited mobility. Goal was for R7 to maintain current level of function. Interventions included nursing rehabilitation: active range of motion per OT (occupational) and PT (physical therapy) notes. In addition, the care plan dated 3/8/25, indicated R7 had osteoarthritis and would be/remain free of complications related to arthritis pain including pain, swelling and difficult mobility.</p> <p>R7's Kardex printed on 5/29/25, indicated staff should encourage routine physical activities and encourage walking on a daily basis.</p> <p>Restorative nursing recommendations by physical therapy assistant (PTA)-C dated 11/5/24, and titled: RNP (restorative nursing program) and Walking Program, indicated the following recommendations:</p> <ul style="list-style-type: none"> -- Upper extremity 1 # dowel 2 X 10 all planes. -- LE (left extremity) AROM (assisted range of motion) in seated, all motions with 2 # GTB (unknown abbreviation), 2 X 15 -- NuStep (recumbent exercise machine) L (level) 2-3 X 10 minutes -- Walk using FWW (front wheel walker), CGA (contact guard assist), gait belt and WC (wheelchair) to following averaging 50 feet per bout. -- Complete 5 X / week. <p>During an interview on 5/27/25 at 2:36 p.m., R7 stated they used to walk me in the hallway, but not anymore, I don't know why. would like to walk in the hallway to stay limber.</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 an observation on 5/29/25 at 8:47 a.m., R7 was sitting in her recliner. R7 spent most of the day observed in recliner unless she was at meals.</p> <p>During an interview on 5/29/25 at 8:49 a.m., nursing assistant (NA)-D stated the facility used to have a restorative aide, then due to low census the position was eliminated. NA-D stated NA's were never instructed they were supposed to start doing restorative nursing cares with residents. NA-D stated R7 usually stayed in her room except for church and some music programs.</p> <p>During an interview on 5/29/25 at 9:06 a.m., NA-B stated R7 was on a restorative nursing program and that NA-B did ROM exercises to R7's arms. When asked how NA-B knew what kinds of restorative exercises to do with R7, NA-B stated it was listed in POC (Point of Care) in the EMR. (POC was where NA's looked for individualized tasks/care for residents and documented when completed).</p> <p>During review of R7's POC on 5/29/25, at 9:08 a.m., did not list any restorative nursing functions, including ROM or ambulation.</p> <p>During an interview on 5/29/25 at 10:09 a.m., with the director of nursing (DON) and administrator, the administrator stated the facility used to have a restorative aide - nursing assistant (NA)-C, who went on a leave of absence and didn't return. Her employment ended on 1/14/25. The administrator stated now restorative nursing was done by all NA's, and therapy staff helped, however the DON admitted they had not communicated that to NA's nor trained them how to perform the restorative nursing recommendations from PT. Both the DON and administrator indicated their restorative nursing program stopped when NA-C left.</p> <p>Facility Restorative, Nursing Care Implementation and Screening policy dated 11/27/24, indicated the purpose was to provide appropriate restorative nursing care to each resident, to identify residents appropriate for restorative nursing program. Each resident would receive restorative nursing care to the extent possible based on individual needs. Restorative aide would be trained in rehabilitation/restorative techniques per job description. The goal of restorative nursing care was to attain and maintain the maximum possible independence and/or prevent rapid declines through their interventions for each resident. Residents were provided appropriate treatment and services to attain/maintain functional abilities of ADLs. The restorative nurse had the overall responsibility and accountability for the restorative program. In the event the location did not have a designated restorative nurse, the responsible and accountability remained with the DON or designee.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure proper infection control practices were followed for 1 of 1 resident (R12) reviewed for infection control when the tip of urinary drainage tubing was observed laying on the bathroom floor. In addition, the facility failed to clean and maintain reusable urinary drainage bags to minimize the potential for infection for R12.</p> <p>Findings include:</p> <p>R12 face sheet provided on 5/29/25, included diagnoses of urinary retention, hydronephrosis (excess fluid in kidney), flaccid neuropathic bladder (underactive bladder).</p> <p>R12's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R12 had intact cognition, clear speech, could understand and be understood. R12 had an indwelling urinary drainage catheter and required supervision with most ADLs, including walking.</p> <p>R12's physician orders included: Insert 16 F (French) catheter with 10 ml (milliliter) balloon every 30 days for urinary retention. (There was no order for a leg bag. Facility policy indicated: leg bags may be used with a physician's order).</p> <p>R12's care plan dated 4/28/25, indicated enhanced barrier precautions related to indwelling catheter. The care plan did not identify leg bag or cleaning the overnight urinary drainage bag using vinegar/tap water solution, and the technique to prevent risk of infection. Care plan dated 4/13/25, indicated R12 had an infection of the urinary system and would be free from complications.</p> <p>R12's Kardex printed on 5/29/25, indicated R12 had an indwelling foley catheter. The Kardex did not identify a leg bag or cleaning the overnight urinary drainage bag using vinegar/tap water solution, and the technique to prevent risk of infection.</p> <p>During an observation on 5/27/25 at 11:43 a.m., in R12's bathroom, a gray plastic basin was sitting on the floor next to the toilet/under the sink. In the basin was a large jug of vinegar, a urinal without a cover, and urinary drainage bag. The distal end of the tubing of the urinary drainage bag was setting on the floor, no cap on the end. Two clear plastic graduates were sitting on the handicapped bar next to the sink/toilet. One was dated 1/18/25, and had a catheter tip syringe in it and the other graduate was not dated.</p> <p>During an observation and interview on 5/27/25 at 11:48 a.m., nursing assistant (NA)-A who was preparing to empty R12's leg bag was asked to look at the urinary drainage bag in the bathroom. NA-A stated the tubing shouldn't be on the floor because it could cause R12 a bladder infection. NA-A stated the urinary drainage bag was R12's overnight urinary drainage bag. NA-A stated when staff removed it in the morning to attach R12's leg bag, they put half tap water and half vinegar in a graduate, then using the cath-tip syringe put the solution into the distal end of the tubing which then flowed into the bag.</p> <p>During an observation on 5/27/25 at 1:24 p.m., observed the urinary drainage bag tubing still on the bathroom floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 5/27/25 at 1:54 p.m., together with the director of nursing (DON), went to R12's bathroom. The tubing was still on the floor. The DON stated there should be a cap on the end of the tubing; that staff should keep the cap available to reuse it. The DON stated the jug of vinegar, and the urinal shouldn't be in the basin - just the drainage bag with tubing coiled up in it. The DON set the jug of vinegar on the floor and threw away the urinary drainage bag as well as the urinal. The DON stated the urinary drainage bag was changed weekly along with the graduate and syringe. The DON acknowledged according to the date; the graduate had been in use longer than a week. The DON also acknowledged the potential for R12 to obtain a urinary tract infection (UTI) had the contaminated tubing been reattached to his urinary catheter after having laid on the floor.</p> <p>During an observation and interview on 5/28/25 at 9:20 a.m., observed NA-A empty the urine from R12's overnight urinary drainage bag into the toilet. Next, using water from the faucet, NA-A put water in the graduate, then added an approximately equal amount of vinegar for a total of about 200 ml (milliliters). Using a cath tip syringe, NA-A drew up the solution and injected it into the distal tip of tubing of the urinary drainage bag. The solution went into bag. NA-A then capped the distal tip and set the urinary drainage bag in the basin and coiled the tubing on top of the bag. NA-A stated the solution was kept in bag until the bag was used again at night.</p> <p>During an observation and interview on 5/28/25 at 3:30 p.m., together with registered nurse (RN)-B who was also the infection preventionist, went to R12's bathroom. After observing the urinary drainage bag in the basin on the floor, the jug of vinegar, graduate and syringe, RN-B stated she was unaware of the practice of NA's using tap water and vinegar to flush the overnight urinary drainage bags. RN-B stated the organization was looking at ways to reduce urinary tract infections by maintaining a closed catheter system.</p> <p>During an observation on 5/29/25 at 8:44 a.m., observed the overnight urinary drainage bag in the basin on the floor in R12's bathroom. The distal tip of tubing was uncapped and on top of bag and the cap was sitting on another part of the bag.</p> <p>During an interview on 5/29/25 at 10:31 a.m., with the DON and administrator, informed them of findings, including the observation of the uncapped tip of the urinary drainage bag from that morning. The DON stated one of their performance improvement projects was on UTI's. Was aware R12 had a recent UTI.</p> <p>Facility Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen policy dated 4/6/25, indicated:</p> <p>--All closed collection systems that become contaminated by inappropriate technique, leaks or other means are immediately replaced.</p> <p>--Leg bags may be used with a physician's order.</p> <p>--Catheter tubing should never be allowed to touch the floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>--To clean the bag not in use: Be sure to close the bottom port of the bag that was emptied and not in use. Rinse the bag with warm (not hot) soapy water or bacteriostatic solution such as one-part white vinegar and three parts water solution or an appropriate commercial solution. Pour solution into the bag. Swish the solution around being sure to get the corners of the bag. Hint: A 60 ml syringe may be used to get solution into bag, be sure to clean the tip of the syringe with alcohol wipe before use and store in clean dry place. Soak the bag for 30 minutes. Open the bottom drainage port and drain the solution from the bag. Rinse the bag with warm water and hang to dry in the residents restroom covered with a clean towel. g. Cover/cap the tubing once the bag is dry.</p>		