STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Westbrook	149 First Street, Box 218 Westbrook, MN 56183

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34083 Based on observation, interview and document review, the facility failed to update the provider following re-development of an unstageable pressure area for 1 of 1 resident (R2). Findings include: R2's 10/9/24, Annual Minimum Data Set (MDS) assessment identified her cognition was intact, she required extensive assistance from staff for activities of daily living (ADLs), and there were no skin issues identified. R2 had diagnoses of Neurocognitive disorder with Lewy Bodies, urge incontinence, major depressive disorder, anxiety disorder, neuromuscular dysfunction of bladder, osteoporosis, Parkinson's disease, and a history of falls. She was identified as at risk for pressure ulcers but had no unhealed pressure areas at the time of the assessment. R2 had a pressure relief mattress on her bed and her primary mode of transportation was a wheelchair. Observation and /interview on 1/6/25 at 1:30 p.m. with R2 who pulled up her right pant leg to show a Band-Aid covering the outer aspect of her ankle, and reported she had a sore there, but she did not recall when it had occurred or if she had injured the area. She reported staff put her stockings on over the bandage in the morning and took then off when she went to bed at night. The staff changed the band aid, but she wasn't certain how often they did that. Observation on 1/7/25 at 3:19 p.m., of licensed practical nurse (LPN)-A as she performed wound care to R2's right ankle. LPN-A cleansed the wound area with wound cleanser, applied skin prep to the surrounding area and allowed to dry. The wound had a light pink area surrounding a white, scabbed center area. R2 denied any pain or discomfort in the area. LPN-A applied a new Band Aid to the wound and dated and initialed the area. She reported R2 preferred to lie on her right side and interventions included repositioning and encouraging her to position off her right side. (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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/7/25 at 3:25 p.m. with the director of nursing (DON), reported the medical record identified the wound was noted on 12/28/24, and described as the outer aspect red, and the center was pink with a small, scabbed area. She reported the source was unknown, but R2 had a history of reoccurrence of a right ankle wound. The DON reviewed the record and identified the last wound occurrence was in August of 2024. She reported the wound had healed, and remained healed until it was noted again on 12/28/24. A skin assessment was documented on 12/29/24, but there was no documentation the provider had been notified or orders received for a plan of treatment. She reported the record indicated staff were using skin prep on the area and covering with a band aid for protection. The DON reported she would have expected the provider to be notified of the reoccurrence, furthermore, the provider had made rounds on 12/31/24 with no record of the provider being updated of the reoccurrence of R2's ankle wound. The DON obtained measurements of the wound and reported, the size as .2 centimeters (cm) x .2 cm. on 1/9/25, with the area scabbed with no drainage present. Review of the April 26, 2024, Skin Assessment Pressure Ulcer Prevention and Documentation Requirements Policy identified the registered nurse (RN) was to complete a skin assessment to identify any skin issues. When an area was identified the RN was to record the type of wound, the degree of tissue damage, and the location of the wound, measurements, and the stage for a pressure area. The physician was to be notified of the resident condition and ulcer with orders for treatment documented.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34083 Based on observation, interview and document review the facility failed to prevent potential accident hazards for 2 of 2 residents (R7 and R19) due to wandering behaviors into unsecured areas containing hazardous substances. Findings include: R7's, 12/17/24, Significant change Minimum Data Set (MDS) assessment identified she had severe cognitive impairment and wandered throughout the facility including into other resident spaces. R7 had diagnoses of cognitive communication deficit, Cerebrovascular disease affecting left side, anxiety disorder, dementia, and cerebral infarction and wandered within the facility 1-3 days weekly. R19's, 11/27/24, quarterly MDS identified she had severe cognitive impairment, demonstrated verbal and physical behaviors directed toward others, and wandered throughout the facility and into other resident spaces and wandered 1-3 days weekly. Observation on 1/8/25 at 7:33 a.m. noted the tub room door open with no staff in attendance or in the immediate area outside of the tub room. Inside the room located beside the whirlpool tub a white cabinet had both doors open displaying personal care products including Skin protectant cream; hand lotion; skin cleaner; brushes; combs; body spray; hair spray; body powder; deodorant; nail files; and an electric razor. A pair of scissors, tweezers and a nail clipper were on the top of the cabinet along with a large jug of Thera Sol and a spray bottle of Rapid Multi disinfectant cleaner. The items were within reach of a resident ambulating or seated in a wheelchair who could enter the room. The removable bath chair base was located on the floor on the other side of the tub and could present a fall risk to a resident on that side of the tub. At 7:35 a.m., R19 was observed transporting herself in her wheelchair as she proceeded into the tub room, looked around and moved toward the cabinet. Unidentified staff were noted to pass by the room and glance in, but failed to investigate what R19 was doing in the unsecured tub room, as they passed by. R19 moved toward the cabinet reaching her hand out, as she was mumbling but was not able to reach the cabinet due to surveyor standing in front of it. R19 continued to move around the room, bumping items with her wheelchair before turning and exiting the room transporting herself down the hall. No staff checked on R19 or questioned what she was doing in the open and unattended tub room. Interview on 1/8/25 at 7:45 a.m. with the administrator reported the tub room should not have been left open and unattended, and the cabinet containing personal care items, in addition to the cleaning products on top of the cabinet should have been secured. The administrator confirmed R19 had severe cognitive impairment and was not aware of safety issues that could have occurred with the items in and on the cabinet. 47497 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/6/25 at 12:20 p.m., a room at the end of the 300-wing hallway across from a sitting area had an open door. Inside the room was a desk against the wall. The desk had 2 bottles labeled Drano (a toxic solution used for clogged drains), a cart next to the desk had 2 cans labeled WD-40 (a flammable solvent), on the bottom shelf of another utility cart was a box labeled [NAME] (a pest control solution), an aerosol can labeled Lysol (disinfectant spray), an aerosol can labeled [NAME]-Eye 123 Primer, and multiple hand held tools including drills, drill bits, and screw drivers. Interview on 1/6/25 at 12:44 p.m., with NA-(A) identified they do have 2 residents who wander. R7 likes to walk up and down the hallways and R19 likes to sit by the doors at the end of the 300-wing (across from the above mentioned room). They both have a diagnosis of dementia. Observation on 1/6/25 at 12:50 p.m., unsecured room containing chemicals remains open, no residents or staff were observed in the area during the observation. Interview on 1/6/25 at 12:50 p.m., with the administrator identified the door should always be locked. She agreed there are toxic chemicals in the room that need to always be secured for the safety of the residents and any children that may be visiting the facility. She further identified that the facility has residents with diagnosis of dementia that could be at risk. The maintenance director was unavailable for interview. Review of the undated Procurement and Storage of Equipment, Products, and Supplies policy identified the facility was to ensure that all chemicals and disinfectants are labeled and stored in a manner that eliminates risk of improper use, contamination, inhalation, skin contact or personal injury. Housekeeping products and supplies should not be stored in resident rooms or units. Store these items in a locked cabinet and/or storage rooms as appropriate.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 34083 Based on interview and document review the facility failed to ensure that consultant pharmacist reviews were completed monthly for 3 of 5 residents (R10, R19, and R21) reviewed for unnecessary medications. Findings include: R21's 10/30/24, quarterly Minimum Data Set (MDS) assessment identified R21 had severe cognitive impairment, and had behaviors of wandering, exit seeking, and verbal and physical agitation toward staff. She required extensive assistance with activities of daily living (ADLs). R21 ambulated using a 4 wheeled walker with assistance of staff and was seen by therapies. She had pain due to a pelvic fracture because of a fall and received both scheduled pharmacological and non-pharmacological pain interventions. R21 had diagnoses of Alzheimer's disease, major depressive disorder, pain in her feet, dementia, anxiety disorder, and adult personality disorder with behaviors. R21 received scheduled medications including an antipsychotic, antidepressant, and antianxiety. Safety measures were identified due to attempts to self-transfer and repeated falls. R21's monthly consulting pharmacist reviews between July through December 2024, identified there had been no documented pharmacist review completed for the months of November and December 2024. 47497 R19's 11/27/24, quarterly Minimum Data Set (MDS) assessment identified her cognition was severely impaired, she required extensive assistance with activities of daily life (ADL's) and had verbal and physical behaviors directed towards others, rejected care and at times wandered throughout the facility. R19 had diagnosis of dementia, aphasia, anxiety, and depression and was taking psychotropic medications for depression and anxiety. R19's monthly consulting pharmacist reviews between July through December 2024, identified there had been no documented pharmacist review completed for the months of November and December of 2024. 39988 R10's 12/23/24, quarterly Minimum Data Set (MDS) assessment identified R10's cognition was intact. R10 had some verbal behaviors directed towards others and required extensive to total assistance with cares. Daily he received insulin, an anticoagulant, diuretic, antidepressant, and antipsychotic medication. The assessment identified diagnoses of hypertension, diabetes, hyperlipidemia, stroke, bilateral weakness, seizure disorder, and depression. R10's monthly consulting pharmacist reviews between July through December 2024, identified there had been no documented pharmacist review completed for the months of November and December 2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/8/24 at 10:12 a.m., with administrator identified that the facility had concerns with the consulting pharmacist, and she had reached out to national campus who was also working with the pharmacist. The facility had trouble getting pharmacy reviews completed timely and they had discussed switching back to Thrifty White. She believed that the reviews had been completed but the facility did not have a copy in house of the review. Not being provided the reviews consistently was a problem for being able to communicate the recommendations to the provider. The facility was consistently calling the pharmacy and asking for the information. Additionally, she reported that she had tried to reach out to the pharmacist however, the pharmacist was out ill and unavailable. The pharmacist was unavailable for interview. There was no pharmacy contract provided during the survey.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34083 Based on interview and document review the facility failed to investigate and/or document the justification for a prophylactic antibiotic for 1 of 1 resident (R7). Findings include: R7's 12/17/24, Significant change Minimum Data Set (MDS) assessment identified she had severe cognitive impairment and wandered throughout the facility including into other resident spaces. R7 had diagnoses of cognitive communication deficit, Cerebrovascular disease affecting left side, anxiety disorder, vascular dementia, and cerebral infarction. R7 was frequently incontinent of bowel and bladder and required staff assistance for toileting. R7 was admitted in November of 2024, with orders for Macrobid (antibiotic)Capsule 100 milligrams (mg) by mouth (PO) daily (QD) with the diagnosis of chronic urinary tract infection (UTI). A urine test was completed 11/13/24 with negative results, and no culture and sensitivity was completed. There was no documentation to support the reason for the urine test, or any signs and symptoms (S/S) the resident had displayed. The preadmission assessment dated [DATE] by the MD, contained documentation R7 was receiving Macrobid 100 mg PO QD at 8:00 p.m., but there was no identified start or stop date, nor rational identifying a reason for prophylactic use of an antibiotic. R7's current undated care plan identified she had bowel and bladder incontinence related to vascular dementia, weakness, hallucinations, confusion, was at risk for falls, and low blood pressure. R7 had a history of frequent UTI's. Interventions included encouraging fluids during the morning and afternoon, monitor for S/S of UTI's, and offer toileting/repositioning Q 3 hours (H). There was no mention of R7 receiving a prophylactic antibiotic. Interview on 1/6/25 at 4:42 p.m. with licensed practical nurse (LPN)-B reported R7 was currently receiving a prophylactic antibiotic Macrobid 100 mg PO Q HS for chronic UTI's, with an original order date of 11/6/24 and no end date ordered. Interview on 1/7/25 at 11:14 a.m., with nursing assistant (NA)-A reported she was aware of the S/S of a UTI and would immediately report them to the charge nurse. She reported she had frequently assisted R7 with toileting and was not aware of any S/S of a UTI. Interview on 1/7/25 at 3:43 p.m. with the director of nursing (DON) identified R7 had been admitted with an order for a prophylactic antibiotic for recurrent UTI's. She was not aware of any evaluation for the need to continue the prophylactic antibiotic, or investigation taking place to identify the need for R7 to remain on the antibiotic. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/8/25 at 1:25 p.m. with R7's primary provider (medical director) reported he was not certain when R7 had initially been started on Macrobid for a diagnosis of recurrent UTI's, but it had been prior to admission to the facility. The MD reviewed R7's clinic record and reported the original order was dated October of 2023 and she had been receiving the medication since that time. He had not investigated the continued need for the antibiotic at the time of admission, nor had R7 experienced any identified S/S of a UTI since time of admission. R7 had been admitted from an Assisted Living situation and was likely receiving better personal care currently than she had been able to provide for herself in her previous living situation. He was not aware of any previous referral to urology or infectious diseases and the continued use of the prophylactic antibiotic would need to be investigated further. The MD noted continued use justification should be brought forward for discussion with the MD if criteria was not met. Interview with the Infection Preventionist on 1/8/25 at 2:31 p.m. identified she was aware R7 was receiving a prophylactic antibiotic, but she had not identified this as an area of concern to investigate further under antibiotic stewardship criteria. A policy for unnecessary medications, and/or use of prophylactic antibiotic use was requested but not provided by the end of the survey period.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39988 Based on observation, interview, and document review the facility failed to appropriately prepare unpasteurized eggs, monitor temperatures of food prior to serving, and to monitor the refrigerator and freezer temperatures to prevent food borne illnesses. Findings include: Observation and interview on 1/6/25 at 10:52 a.m., with the dietary manager (DM) during a tour of the kitchen, the DM identified the eggs located in the refrigerator in the prep area were unpasteurized. The DM reported that the facility cooked the unpasteurized eggs hard. She further reported she had forgotten to provide temperature monitoring sheets for the month of January, and temperatures had not been monitored and documented for the refrigerators and freezer. She confirmed that the refrigerator and freezer temperatures were to be monitored twice a day. Interview on 1/7/25 at 7:58 a.m., with the DM identified she ordered eggs through Sysco, and pasteurized eggs were not available at the time of the order. She stated she was aware that the unpasteurized eggs were to be cooked hard as they could not be served with a soft yoke. Review of the current facility menu identified eggs for breakfast: Week 1-Sunday scrambled eggs, Monday no eggs, Tuesday no eggs, Wednesday egg of choice, Thursday scrabbled eggs, Friday egg of choice, and Saturday no eggs. Week 2- Sunday cheesy eggs, Monday no eggs, Tuesday no eggs, Wednesday scrambled eggs, Thursday no eggs, Friday scrabbled eggs, and Saturday no eggs. Week 3-Sunday egg of choice, Monday cheese omelet, Tuesday no eggs, Wednesday scrambled eggs, Thursday cheese and egg casserole, Friday egg of choice, and Saturday no eggs. Week 4-Sunday egg and cheese sandwich, Monday no eggs, Tuesday scrambled eggs, Wednesday no eggs, Thursday egg of choice, Friday cheese omelet, and Saturday no eggs. Observation on 1/7/25 at 9:07 a.m., during medication pass, R5's plate was observed to have what looked like yellow egg yolk smeared on about 1/4 of the plate and on the plates raised edges. There were two other residents in the dining room eating scrabbled eggs with no indication of egg yolk on their plates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 1/8/25 at 7:47 a.m., with dietary cook (C)-A who identified residents can get their eggs scrabbled or over easy. If she made scrambled eggs, she used the liquid eggs from the carton and for the over easy eggs she used the eggs out of the refrigerator. She reported she was unaware if the eggs were pasteurized or unpasteurized. She revealed she had not received any education on the use of pasteurized or unpasteurized eggs and how to prepare them. She reported R27 had requested runny eggs this morning and she made them runny for her. She then revealed that R5, R25, and R26 also requested their eggs runny sometimes. She then said, she believed the eggs were unpasteurized and that they had been getting the unpasteurized eggs for a while now. She reported she was unaware unpasteurized eggs needed to be hard cooked and not served runny. Interview on 1/8/25 at 7:54 a.m., with the dietary assistant (DA)-B identified that he did not cook, and he had not had any training on handling unpasteurized eggs. He confirmed there were residents in the facility who liked their eggs runny or soft for breakfast. Interview on 1/8/25 at 8:13 a.m., with R5 identified she liked eggs, and she usually ordered them fried, but did occasionally like them soft but not runny. Interview on 1/8/25 at 8:16 a.m., with R26 identified he liked eggs. He was unable to tell how he liked or received his eggs. Interview on 1/8/25 at 8:20 a.m., with the director of nursing (DON) identified the dietary manager ordered the eggs for the facility. She reported that if the facility had unpasteurized eggs, she would expect the dietary staff to be trained on handling unpasteurized eggs. Interview on 1/8/25 at 8:24 a.m., with the administrator identified unpasteurized eggs should not be served runny and she would expect all dietary staff to know how to handle unpasteurized eggs. She was unaware that the facility had been getting unpasteurized eggs and stated the facility should only be ordering pasteurized eggs. She then picked up the phone and called the dietician and the dietician stated on speaker phone the only time the facility should use unpasteurized eggs was if it was for baking. The dietician further reported if unpasteurized eggs were to be used for breakfast that they had to be cooked hard and all staff should be trained on how to handle unpasteurized eggs. Interview on 1/8/25 at 8:39 a.m., with DM identified she was still unable to get pasteurized eggs and she had forgotten to tell C-A the unpasteurized eggs could only be served cooked hard. For residents who like them served soft she reported they were to explain to the resident that they could not make soft eggs at this time and offer to serve the eggs hard or scrabbled. She said when she went to order the pasteurized eggs from Sysco they were listed out of stock. She stated, I'm not going to try to pull the wool over your eyes or lie and confirmed she had not been monitoring the temperatures for the food, refrigerators, or freezer. She reported she knew the refrigerator and freezer were working and she had set a bad example for others. She confirmed she knew she was supposed to monitor and document but she just did not do it. She said she had let a lot of things go that she was supposed to do but she had been working 7 days a week for a very long time and she just let things go. She confirmed she had no temperature logs to provide for food monitoring, refrigerators, or freezer. Interview on 1/8/25 at 9:18 a.m., with the dietician identified she would expect staff to monitor and document food temperature prior to serving, in addition to monitoring refrigerator and freezer temperatures. She reported she was surprised that it had not been getting completed. She was unaware that anyone was having trouble getting pasteurized eggs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 1/8/25 at 9:35 a.m., with the Sysco customer care identified there had been a problem with obtaining pasteurized eggs at some warehouses. He revealed that his records showed pasteurized eggs were unavailable at time of the facilities November and December orders. Facilities are not allowed to use unpasteurized eggs and other facilities had been ordering liquid eggs. He was unsure why the pasteurized eggs were unavailable and said Sysco was at the mercy of what they could get in the warehouses, but it appeared to be resolved at this time. Interview on 1/8/25 at 10:12 a.m., with the administrator identified she had all the unpasteurized eggs removed from the building, she set up mandatory education for dietary staff prior to starting their shift and arranged for the dietician to come today to re-educate the dietary manager. Interview on 1/8/25 at 1:21 p.m., with the medical director identified he would expect the facility to be following policies and procedures for monitoring and documenting food temperatures, refrigerator, and freezer temperatures to prevent food borne illnesses. He further confirmed unpasteurized eggs should not be served soft or runny due to the risk of Salmonella illness. Review of 12/16/24, Food Temperature Monitoring policy identified food temperatures are to be taken and documented prior to each meal. Additionally, periodic temperatures should be taken during or at end of meal to ensure temperatures maintain acceptable ranges. Review of 5/7/24, Food-Supply Storage-Food and Nutrition policy identified all refrigerators and freezers in the nutrition department and dining room are recorded twice daily. Review of 3/11/24, Ordering-Food and Nutrition Service policy identified ordering food will be completed timely and can be completed by ordering through Food Samaritan NET Purchasing System (DSSI) or by ordering directly from the vendor. If questions or concerns staff should reach out by submitting question directly to [NAME] Service Portal, or by contacting National Campus. A policy for use of unpasteurized eggs was requested but not provided.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 34083 Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included development of protocols and a system to monitor antibiotic use, to ensure appropriate antibiotics were utilized to prevent antibiotic resistance. This deficient practice had the potential to affect all 29 residents who resided in the facility. Findings include: Review of the September 2024, October 2024, and November 2024 infection control (IC) antibiotic stewardship identified the following information: Resident name, Medication prescribed, Classification of the drug, start date, end date, ordered days of therapy, actual days of therapy, Route, and abbreviation for infection without a legend to identify the infection abbreviations. The data for each report showed in: 1.) September 2024, 14 antibiotic orders with 231 days of therapy were included on the monthly IC report. Nine residents were identified as having received antibiotic therapy (R3, R5, R11, R17, R19, R24, R31, R182 and R183). 2.) October 2024, 10 antibiotic orders with 100 days of therapy. R31 was identified as receiving an ongoing oral antibiotic, but there was no identified rational, or documentation of a physician contact to identify and document the need for continued use. Three residents (R2, R8 and R11) were identified as on antibiotics for a urinary tract infection (UTI). 3.) November 2024, 16 antibiotic orders with 75 days of therapy were documented. R7 was admitted with physician orders for an antibiotic for a prophylactic antibiotic due to a history of UTIs. The record failed to identify any consult with the physician related to Antibiotic Stewardship, the continued need for the antibiotic, and any rational or investigation as to when it had been initiated, a stop date, or follow up testing indicated. R6, R7, R13, R15, R18, R23, R24, R27, R187, R188, and R189 also received antibiotic treatment in November 2024. There was no documentation of symptoms, a time out completed, or culture/sensitivity results with notification of the physician to identify if the appropriate medication was in use or should be changed or discontinued. There was also no indication staff had re-assessed the resident's following completion of therapy or notified their physicians to identify if symptoms had resolved or if there was a need to change the medication or continue medication for a specific period. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Westbrook	149 First Street, Box 218 Westbrook, MN 56183

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 1/8/25 at 1:25 p.m. interview with Physician (MD)-A reported he was not certain when R7 had started taking an antibiotic for a diagnosis of recurrent UTI's. Upon review of his clinical record, he identified the original order was in October of 2023. He had not investigated the use of the antibiotic at the time of admission, nor was he aware of R7 having any symptoms of a urinary tract infection since she had been admitted to the facility. He further commented he did not recall being asked about continued need for the antibiotic and reported he was not aware of any investigation or referrals to urology or infectious disease related to the need for continued use of the antibiotic. MD-A stated he felt continued use of an antibiotic for an extended period should be investigated further and there should be an end date to assess the need for continuation of a medication. MD-A also voiced agreement this was an area the IP should be aware of and questioning the MD for rational for the need of continued use or if the medication was effective Interview and document review on 1/8/24 at 2:30 p.m., with the IP reported she had not performed timeouts or tracked the antibiotic use through to resolution to identify if the antibiotic was appropriate, or the need to alter or change therapy was identified. The IP stated she had been on vacation and had not completed the December tracing information at the time of survey and agreed she had not performed appropriate antibiotic stewardship. There was no mention of any staff member covering the IP duties while she was away from the facility. Interview on 1/9/25 at 9:43 a.m., with the director of nursing (DON), identified she would expect a thorough IC program to include appropriate antibiotic stewardship. She was unaware no one was assigned to monitor the program when the IP had been on vacation. Interview on 1/9/25 at 9:50 a.m., with the administrator identified she agreed antibiotic stewardship was lacking appropriate oversight. The IP had been on vacation and had failed to identify anyone designated to cover infection control surveillance while they were on vacation. Review of the 12/19/24 Antibiotic Stewardship-Rehab/Skilled policy identified staff were to follow Loeb's criteria for initiating antibiotics (which, when met, indicate that the resident likely has an infection and that an antibiotic might be indicated, even if the infection has not been confirmed by diagnostic testing).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 34083 Based on interview and document review, the facility failed to ensure 1 of 1 infection preventionist (IP) had appropriate training and oversight of the infection control (IC) program to management by performing current, daily cumulative infection control surveillance activities, maintain documentation of incidents, findings, and any corrective actions required, and ensure the IC program continued in her absence. Findings include: Refer to F880 and F881 Review of the September through December 2024 logs identified infection surveillance had not been tracked through to resolution, no tracking or trending had occurred, and December 2024 had not been performed. Interview on 1/8/25, at 2:10 p.m. with the IP identified she tracked staff illness with an illness/absence report, which was completed when a staff member called in due to illness of themselves or a child. The process was for the charge nurse to complete the form and provide a copy to the IP, director of nursing (DON), and office manager who completed the schedule. The IP reported she collected the forms and completed a report at the end of each month that was presented to the Quality Assurance (QA) committee. The IP reported she recalled R23 also being tested for Norovirus, but she had not included her on the log, and no initial clinical monitoring documentation had been completed. She stated she did not have an explanation for why this did not occur, but it was not on her log. The IP reported she had not been including documentation on surveillance or resolution of infections and when a resident had been admitted with orders for a prophylactic antibiotic she had not investigated or questioned the order. She identified completion of the IP training and provided a copy of her certificate, but stated she would like to receive additional education on how and what she needed to investigate and document, in addition to finding a format that included the necessary information. The reporting of infections and/or antibiotic use was received electronically if staff completed the documentation correctly. She also stated she was told by staff, or a note was left for her, for antibiotic use which she recorded on her log form. She made no follow-up to identify antibiotic stewardship had occurred, including antibiotic timeouts. The IP was unaware of the need to report potential Norovirus outbreak and had not correlated GI illness or put measures in place to prevent potential spread and ensured staff remained off work until 72 hours after symptoms subsided. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 1/9/25 at 9:43 a.m., with the DON reported her expectation for the IP to correlate potential outbreak concerns related to staff and resident illness and investigate root cause with potential intervention. The DON identified there was a checklist that was supposed to be completed and sent to the IP and DON and she expected the IP to follow the facility policy and procedures about IC surveillance and documentation. She confirmed antibiotics should not be started until a culture was received and 48 hours after an antibiotic was started a time out was implemented with a form completed and sent to provider. She reported the physician was to review the appropriateness of the antibiotic and make the determination if it should continue or be changed. She confirmed R7 had been admitted on a prophylactic antibiotic and there was no documentation to indicate there had been an attempt to investigate need for continued use, or an attempt to implement alternate treatments. Interview on 1/9/25 at 9:50 a.m., with the administrator reported she was not aware of a possible correlation between the resident who was hospitalized with Norovirus and reported staff illness with the same symptoms. She reported she would expect staff or family illness to be investigated and staff is not allowed to return to work until the appropriate time follow resolution of symptoms. She stated she would expect documentation to be maintained to confirm this had taken place. She reported the IP had been on vacation and failed to identify anyone designated to cover infection control surveillance while the IP was on vacation. Review of the December 2, 2024, Infection Prevention and Control Program Policy identified the program was to work to prevent, identify, investigate, and report in the attempt to control infections and communicable diseases for residents, staff, and visitors in a facility. The program was to follow the nationally accepted standards, and guidelines for infection control. The program was to include an acceptable system to monitor and document infection control and prevention. The program was to be reviewed annually by the IP or designee, to ensure compliance. The IP utilizes surveillance date to identify outcomes, trends and patterns with results communicated to the QAPI committee.