STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. Building B. Wing	10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Blackduck	172 Summit Avenue West Blackduck, MN 56630

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect pressure ulcer staging for 1 of 3 residents (R1) reviewed with pressure ulcers.Findings include:R1's admission Record indicated she admitted to the facility on [DATE]. R1's diagnosis included dehydration, Parkinson's disease, anxiety and weakness. R1's Braden Scale for Predicting Pressure Sore Risk dated 10/16/25, indicated a score of 13, which indicated moderate risk.R1's Wound Data Collection dated 10/16/25 at 5:15 p.m., identified an unstageable decubitus (a type of skin injury caused by prolonged pressure on the skin, which restricts blood flow and can lead to tissue damage and death) ulcer on the left buttock that measured 3 centimeters (cm) x .75 cm. Surrounding skin pink and intact. Wound bed 100% granulation tissue (described as being red and moist, with a bumpy or granular appearance due to new capillary buds, fibroblasts, and collagen), which indicated a stage III pressure ulcer. Wound margins were intact and pink.R1's Wound Data Collection dated 10/16/25 at 5:24 a.m., identified a wound (no description) on the left iliac crest (the curved area on the sides of the hip bones of the pelvic girdle) that measured 3.5 cm x 1 cm x .75 cm. Drainage present on dressing, surrounding tissue intact and tunneling (a chronic wound with an opening that extends into a narrow passageway or channel beneath the skin's surface) present. Wound characteristic not completed. Drainage amount indicated moderate, color indicated purulent (white, yellow, green, brown, or sometimes pink-tinged).R1's Wound RN (registered nurse) assessment dated [DATE] at 5:32 a.m., indicated an unstageable pressure ulcer to the left buttock, present on admission. The assessment indicated, continue with current plan of treatment.R1's Wound Data Collection dated 10/22/25 at 8:09 a.m., identified a stage I pressure ulcer (the earliest stage of a pressure injury, characterized by reddened, unbroken skin that does not turn white when pressed) to the left buttock that measured 3 cm x .35 cm. Wound characteristics indicated 100% granulation tissue. Surrounding tissue identified as macerated (softened, wrinkled tissue due to moisture) and reddened. RN to assess change in wound status.R1's Wound Data Collection dated 10/22/25 at 11:50 a.m., identified a wound on the coccyx (the final bone at the bottom of the spine) that measured 2.5 cm x 1 cm. Description was left blank. Wound characteristics indicated 100% granulation tissue. Surrounding tissue macerated and reddened. RN to assess change in wound status.R1's Wound RN assessment dated [DATE] at 3:40 p.m., identified a non-pressure related wound on the iliac crest. Tissue loss indicated full thickness loss (a severe wound that extends through all layers of the skin and into underlying structures like fat, muscle, tendon, or bone). Physician was notified regarding wound status, requesting wound consult.R1's Wound RN assessment dated [DATE] at 3:42 a.m., identified an unstageable pressure ulcer on the left buttock. During interview on 10/31/25 at 11:55 a.m., RN-B indicated she was new to her role and stated when coding the MDS, she looked at the nursing data collection. RN-B said the data collection she looked at said R1 had an unstageable pressure ulcer on admission which was why she coded it that way. RN-B said there were some issues with the facilities wound charting.

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure a baseline care plan related to pressure ulcers was developed for 1 of 3 resident (R1) who admitted to the facility with a pressure ulcer and developed pressure ulcers.Findings include:R1's admission Record indicated she admitted to the facility on [DATE]. R1's diagnosis included dehydration, Parkinson's disease, anxiety and weakness. R1's Braden Scale for Predicting Pressure Sore Risk dated 10/16/25, indicated a score of 13, which indicated moderate risk.R1's Wound Data Collection dated 10/16/25 at 5:15 p.m., identified an unstageable decubitus (a type of skin injury caused by prolonged pressure on the skin, which restricts blood flow and can lead to tissue damage and death) ulcer on the left buttock that measured 3 centimeters (cm) x .75 cm. Surrounding skin pink and intact. Wound bed 100% granulation tissue (described as being red and moist, with a bumpy or granular appearance due to new capillary buds, fibroblasts, and collagen), which indicated a stage III pressure ulcer. Wound margins were intact and pink.R1's Wound Data Collection dated 10/16/25 at 5:24 a.m., identified a wound (no description) on the left iliac crest (the curved area on the sides of the hip bones of the pelvic girdle) that measured 3.5 cm x 1 cm x .75 cm. Drainage present on dressing, surrounding tissue intact and tunneling (a chronic wound with an opening that extends into a narrow passageway or channel beneath the skin's surface) present. Wound characteristic not completed. Drainage amount indicated moderate, color indicated purulent (white, yellow, green, brown, or sometimes pink-tinged).R1's Wound RN (registered nurse) assessment dated [DATE] at 5:32 a.m., indicated an unstageable pressure ulcer to the left buttock, present on admission. The assessment indicated, continue with current plan of treatment.R1's Wound Data Collection dated 10/22/25 at 8:09 a.m., identified a stage I pressure ulcer (the earliest stage of a pressure injury, characterized by reddened, unbroken skin that does not turn white when pressed) to the left buttock that measured 3 cm x .35 cm. Wound characteristics indicated 100% granulation tissue. Surrounding tissue identified as macerated (softened, wrinkled tissue due to moisture) and reddened. RN to assess change in wound status.R1's Wound Data Collection dated 10/22/25 at 11:50 a.m., identified a wound on the coccyx (the final bone at the bottom of the spine) that measured 2.5 cm x 1 cm. Description was left blank. Wound characteristics indicated 100% granulation tissue. Surrounding tissue macerated and reddened. RN to assess change in wound status.R1's Wound RN assessment dated [DATE] at 3:40 p.m., identified a non-pressure related wound on the iliac crest. Tissue loss indicated full thickness loss (a severe wound that extends through all layers of the skin and into underlying structures like fat, muscle, tendon, or bone). Physician was notified regarding wound status, requesting wound consult.R1's Wound RN assessment dated [DATE] at 3:42 a.m., identified an unstageable pressure ulcer on the left buttock. R1's Nursing Admit Re-Admit Data Collection dated 10/16/25, indicated skilled services to include wound care. Skin integrity assessment indicated a dehisced (partial or total separation of previously approximated wound edges, due to a failure of proper wound healing) scar on the left side of her abdomen, left buttock: crease area unstageable ulcer due to previous location and a scratch on her arm.R1's care plan dated 10/16/25, identified a self-care deficit related to weakness. The care plan directed staff to assist with bed mobility, transfers and toilet use. The care plan identified a potential and actual impairment to skin integrity and open wounds and an unstageable pressure ulcer on the left buttock. The care plan directed staff to monitor size, location and treatment of skin injury, provide pressure relieving device and or skin protective device (unspecified), on heels, elbows, etcetera (not specified). Frequency not specified. The care plan indicated avoid positioning on back. R1's care plan identified Parkinson's disease and indicated, monitor voiding pattern and continence and implement toileting program if needed. During interview on 10/31/25 at approximately 1:00 p.m., the director of nursing (DON) acknowledged R1 did not have a baseline care plan and stated the initial care plan was done with assessments and said the nurses can click buttons to add interventions to the care plan. The DON said the nurses must not have clicked the buttons on the assessments to link to the care plan. The DON stated after the initial care plan the MDS coordinator, RN-B completed the care plans.Facility policy Care Plan dated 12/2/24, indicated the baseline care plan includes instructions needed to provide effective and person-centered care of the resident that met professional standards of quality of care. The policy indicated each resident will have and individualized, person-centered, comprehensive care plan to include measurable goals and timetables directed toward achieving and maintaining the residents optimal medical, nursing, physical and functional needs. Any problems, needs and concerns identified will be addressed

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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to perform ongoing and accurate assessment of pressure ulcers for 2 of 3 residents (R1,R3) who were at risk for pressure ulcer development. In addition, the facility failed to implement interventions to reduce the risk for new or worsening pressure ulcers.Findings include:R1's admission Record indicated she admitted to the facility on [DATE]. R1's diagnosis included dehydration, Parkinson's disease, anxiety and weakness. R1's Braden Scale for Predicting Pressure Sore Risk dated 10/16/25, indicated a score of 13, which indicated moderate risk.R1's Nursing Admit Re-Admit Data Collection dated 10/16/25 at 4:33 p.m., indicated skilled services to include wound care. Skin integrity assessment indicated a dehisced (partial or total separation of previously approximated wound edges, due to a failure of proper wound healing) scar on the left side of her abdomen, left buttock: crease area unstageable ulcer due to previous location and a scratch on her arm.R1's Wound Data Collection dated 10/16/25 at 5:15 p.m., identified an unstageable decubitus (a type of skin injury caused by prolonged pressure on the skin, which restricts blood flow and can lead to tissue damage and death) ulcer on the left buttock that measured 3 centimeters (cm) x .75 cm. Surrounding skin pink and intact. Wound bed 100% granulation tissue (described as being red and moist, with a bumpy or granular appearance due to new capillary buds, fibroblasts, and collagen), which indicated a stage III pressure ulcer. Wound margins were intact and pink.R1's Wound Data Collection dated 10/16/25 at 5:24 a.m., identified a wound (no description) on the left iliac crest (the curved area on the sides of the hip bones of the pelvic girdle) that measured 3.5 cm x 1 cm x .75 cm. Drainage present on dressing, surrounding tissue intact and tunneling (a chronic wound with an opening that extends into a narrow passageway or channel beneath the skin's surface) present. Wound characteristic not completed. Drainage amount indicated moderate, color indicated purulent (white, yellow, green, brown, or sometimes pink-tinged).R1's Wound RN (registered nurse) assessment dated [DATE] at 5:32 a.m., indicated an unstageable pressure ulcer to the left buttock, present on admission. The assessment indicated, continue with current plan of treatment.R1's Wound Data Collection dated 10/22/25 at 8:09 a.m., identified a stage I pressure ulcer (the earliest stage of a pressure injury, characterized by reddened, unbroken skin that does not turn white when pressed) to the left buttock that measured 3 cm x .35 cm. Wound characteristics indicated 100% granulation tissue. Surrounding tissue identified as macerated (softened, wrinkled tissue due to moisture) and reddened. RN to assess change in wound status.R1's Wound Data Collection dated 10/22/25 at 11:50 a.m., identified a wound on the coccyx (the final bone at the bottom of the spine) that measured 2.5 cm x 1 cm. Description was left blank. Wound characteristics indicated 100% granulation tissue. Surrounding tissue macerated and reddened. RN to assess change in wound status.R1's Wound RN assessment dated [DATE] at 3:40 p.m., identified a non-pressure related wound on the iliac crest. Tissue loss indicated full thickness loss (a severe wound that extends through all layers of the skin and into underlying structures like fat, muscle, tendon, or bone). Physician was notified regarding wound status, requesting wound consult.R1's Wound RN assessment dated [DATE] at 3:42 a.m., identified an unstageable pressure ulcer on the left buttock. R1's care plan dated 10/16/25, identified a self-care deficit related to weakness. The care plan directed staff to assist with bed mobility, transfers and toilet use. The care plan identified a potential and actual impairment to skin integrity and open wounds and an unstageable pressure ulcer on the left buttock. The care plan directed staff to monitor size, location and treatment of skin injury, provide pressure relieving device and or skin protective device (unspecified), on heels, elbows, etcetera (not specified). Frequency not specified. The care plan indicated avoid positioning on back. R1's care plan identified Parkinson's disease and indicated. monitor voiding pattern and continence and implement toileting program if needed. R1's Kardex (care guide) dated 10/31/25, lacked direction to staff related to mobility, transfers and frequency of repositioning or toileting.R1's discharge Minimum Data Set (MDS) dated [DATE], identified an unstageable deep tissue injury, present on admission.R1's Progress Notes identified the following:10/17/25, Daily vitals, medication administration, dressing changes. Wound still open, no swelling or redness surrounding (wound location not identified). Transfer assist of two with mechanical lift.10/19/25, R1 intermittently incontinent of large amounts of urine and required a full bed change over the past three overnight shifts.10/20/25, Daily vitals, medication administration, dressing changes. Wound is still open, no swelling or redness (wound location not identified). 10/21/25, Daily vitals, medication administration, dressing changes. Wound is still open, no swelling or redness (wound location not identified) 10/22/25, R1 had a 10