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	08/20/2025

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

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure there was a comprehensive assessment and monitoring for prescribing a psychotropic medication for sleep for 1 of 6 (R26); and failed to provide evidence a gradual dose reduction (GDR) or a clinical justification of a psychotropic medication was completed for 1 of 6 residents (R26, R7) reviewed for unnecessary medication and were taking psychotropic medications. Findings include: R26's quarterly Minimum Data Set (MDS) dated [DATE], identified R26 had a moderate cognitive impairment and had diagnoses that included dementia. R26 used antidepressant medication daily. R26's Order Summary Report dated 1/28/25, identified Trazodone HCl oral tablet (an antidepressant primarily used to treat major depressive disorder. It works by increasing serotonin levels in the brain, which can help improve mood, appetite, and energy levels, as well as reduce anxiety and insomnia related to depression. Additionally, trazodone is sometimes prescribed as a sleep aide due to its sedative effects, and it is considered non-addictive.) give 25 milligrams (mg) at bedtime related to unspecified dementia, moderate, with other behavioral disturbance with a start date of 1/28/25. R26's medication record failed to identify R26's sleep was assessed prior to starting Trazodone or after starting the medication to ensure it was effective. R26's care plan revised 2/23/25, identified R26 was on antidepressant medication therapy related to depression. Staff were directed to: Monitor R26's condition based on clinical practice guidelines or clinical standards of practice related to the use of Trazodone, and Consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate. R26's nursing note(s) identified the following: 6/26/25 at 3:46 p.m., identified the Mood/Behavior Committee met and reviewed R26's behavior/mood monitoring: hallucinations/delusions. R26's care plan and interventions were reviewed and continued to be appropriate. R26 had been sleeping a lot more lately. The note failed to identify if R26's sleep was monitored for potential side effects. 7/2/25 at 4:55p.m, identified R26 had a diagnosis of Dementia with Psychotic Disturbances and Dementia with Behavioral disturbances. R26 was alert although not always orientated. At times, R26 had thoughts that he needed to go to Blackduck and that he was not here already. Other times, R26 was fine. PHQ-9 Scored a 03 compared to 00 on last one. R26 said he was tired all the time. R26 (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	answered all questions for interviews. There were no incidents over quarter. Staff were monitoring hallucinations and/or delusions. R26 had 60 occurrences over the quarter. There was four days in the look back period where R26 was confused where he was and got verbally aggressive with staff on one and was hollering out unsure where he was at. All four days involved not knowing where he was. Per staff interview, intervention remained appropriated. IDT Team and Behavior Committee just met and R26's mood/behavior monitoring continued to be appropriate. The note failed to identify if R26 had a sleep assessment and/or if R26's sleep was monitored for potential side effects. R26's Consultant Pharmacist's Medication Review dated 7/11/25, identified R26 was prescribed Trazodone 25 mg at bedtime since 1/28/25. Per CMS guidelines, all psychotropic medications should be considered for a trial dose reduction at least twice within the first year of use. If a dose decrease is contraindicated, rigorous risk/benefit documentation should be provided. A review of recent provider progress notes did not yield a thorough risk/benefit assessment for this patient's psychotropic medications. Suggested course of action: Please evaluate the above psychotropic medications and consider reducing either the trazodone dose on a trial basis or provide clear clinical documentation as to why a dose reduction is contraindicated at this time. However, the form failed to identify a response from R26's physician. R26's medical record failed to identify R26's provider was contacted regarding R26's Trazodone and/or pharmacist's recommendations. R26's care conference note dated 7/22/25 at 1:30 p.m., identified R26 was sleeping and could not wake up. Could not ask R26 or family questions. R26 did a lot of sleeping during the day. Going to talk to the doctor about if he still needs the trazodone. The note failed to identify any further action. During an observation on 8/18/25 at 3:20 p.m., R26 was lying in bed asleep. R26 was sleeping since survey entrance and did not wake when greeted. During an observation on 8/19/25 at 8:34 a.m., R26 was in his room sitting reclined with his feet up in his wheelchair. Blankets covered R26 to his chin. R26's eyes were closed and did not respond when greeted. During an observation on 8/19/25 at 3:42 p.m., R26 was lying in bed asleep on his right side. R26 did not respond when greeted. During an observation on 8/20/25 at 7:32 a.m., R26 was lying in bed with the head of the bed elevated. R26 was covered to his chin with blankets. R26 was asleep and looked up when greeted but laid his head back down and closed his eyes. During an interview on 8/20/25 at 8:50 a.m., nursing assistant (NA)-D stated R26's eyesight was poor. R26 used to make comments like the sun was out but R26 didn't even do that anymore. R26 was pretty set in his ways but R26 did sleep a lot. During an interview on 8/20/25 at 11:08 a.m., registered nurse (RN)-A stated R26 was pretty much like that: pretty laid back, relaxed and slept a lot. RN-A stated he was surprised R26 was on Trazodone because R26 slept a lot, and Trazodone would make R26 even more tired. The only sleep assessment ever conducted for R26 was on 4/4/16. RN-A could not determine why R26 was started on Trazodone and, normally, there was documentation to show why a medication like that was started. When a resident was taking a medication like Trazodone a sleep assessment should be done (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at least annually if not more often. During an interview on 8/20/25 at 11:28, the director of nursing (DON) stated she believed she missed R26 had an appointment with his physician, or she would have requested R26's Trazodone be discontinued. The DON preferred as many medication requests were done during appointments as possible because faxed requests usually did not generate a response. During an interview on 8/20/25 at 3:44 p.m., the consultant pharmacist stated, in general, after a resident was taking Trazodone for 6 months, a gradual dose reduction (GDR) was recommended. During an interview on 8/20/25 at 3:14 p.m., social services designee (SSD)-A stated she completed the annual and quarterly MDS for sections C, D, and F. If there was a Care Area Assessment (CAA) for activities, SSD-A completed that as well. If a resident was on a medication for sleep, SSD-A entered a sleep study as well. SSD-A looked at the diagnosis on the medication sheet and if it stated the medication was for sleep, that would indicate a sleep study was needed. For R26, the medication diagnosis was for hallucinations, and a sleep study was not done. SSD-A stated, for side effects, a sleep assessment was a nursing responsibility. During an interview on 8/20/25 at 3:40 p.m., the DON stated she believed SSD-A did a sleep study for all residents on Trazodone, whether prescribed for sleep or not, because it has a sedating effect. We need to improve our communication. The DON stated a any drug that affected brain activities associated with mental processes and behavior could be considered a chemical restraint and it should be monitored appropriately, and our documentation should show the rationale for use. It should be a team approach and never one nurse requesting a medication like that. Staff should always try other interventions first. During an interview on 8/20/25 at 3:44 p.m., the consultant pharmacist stated, in general, after a resident was taking Trazodone for 6 months, a gradual dose reduction (GDR) was recommended. During that time, the staff should be monitoring the resident and documenting the resident was benefitting from the medication. If for sleep, for example, the resident should be sleeping better. If for mood, it should be controlling their mood. However, staff should be monitoring for side effects of Trazodone because Trazodone could be very sedating. During an interview on 8/20/25 at 4:26 p.m., the administrator stated he expected staff to follow facility policy and procedure. R7's quarterly MDS dated [DATE], identified R7 had moderate cognition. Diagnoses included obsessive-compulsive disorder (mixed obsessional thoughts and acts), dementia, anxiety, depression and psychotic disorder. R7 received antipsychotics on a routine basis. A gradual dose reduction (GDR) had not been attempted or had not been documented by a physician as clinically contraindicated. R7's physician orders identified an order for olanzapine (antipsychotic medication) to be given twice daily related to depression and was started 1/19/23. R7 also received Sertraline given one time a day for depression with psychotic symptoms and was started 6/5/22. R7's medical record lacked evidence a GDR had been attempted or identified a medical justification the resident was on the lowest effective dose within the past calendar year for the olanzapine or sertraline. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's provider nursing home rounds report dated 7/18/25, identified psychiatry followed R7 for anxiety, major depression, dementia with behavioral disturbance, and obsessional thoughts/acts. The note identified R7 had failed previous attempts of medication tapers although failed to identify what medications were tapered and when the medications were tapered. R7's behavioral health visit note dated 7/30/24, identified R7 was to return to the clinic in 6 months or sooner, and continue olanzapine twice daily and sertraline daily. The note failed to identify if the medications were the lowest effective dose or if a GDR should be attempted. On 8/20/25 at 3:33 p.m., the DON stated R7's last psychology visit was more than a year ago and R7 had failed previous attempts for GDR's, however, the DON couldn't remember when GDR was attempted or if they were documented in R7's medical record. The DON stated she thought R7's primary provider was following the residents psych medications but was uncertain since it wasn't documented in the medical record. On 8/20/25 at 4:21 p.m., a message was left for the consulting pharmacist (CP) requesting return call. The facility policy Psychotropic Medications revised 5/12/25, identified throughout the administration of a psychotropic medication, the following must be completed, Mood and behavior documentation must continue to monitor the effect the medication has on the behavior, Monitor for side effects of the medication. If a side effect occurs or worsening of a known side effect is noted, the nurse will make a note in the electronic medical record (EMR) and notify the physician and family/legal representative of this change in condition., Monitor for effectiveness and potential adverse consequences., Gradual dose reductions must be done according to federal regulations. For the guidelines for dose reductions, see the Gradual Dose Reductions section of this procedure, The reduction committee will review the need for psychotropic medications at least every three months and document the rationale for continuing the medication. The committee also will need to evaluate: The resident's target symptoms and the effect of the medication on the severity, frequency and other characteristics, Any changes in the resident's function during the last quarter; this can be done by reviewing the MDS, Whether the resident experienced any medication-related adverse consequences during the previous quarter, and Fax the Fax Communication to Physician to the prescriber. Scan the completed form into OnBase as part of the medical record.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning for 1 of 3 residents (R2) reviewed for pressure ulcers.Findings include:R2's quarterly Minimum Data Set, dated [DATE], identified R2 had moderate cognitive impairment. Diagnoses included dementia, renal insufficiency and anemia. R2 was at risk of pressure injury/ulcer and required substantial/maximal assistance for bed mobility and was dependent on staff for transfers.R2's Braden Scale for Predicting Pressure Sore Risk dated 5/28/25, identified R2 was at high risk for pressure injury/ulcer.R2's care plan revised 5/29/24, included interventions to check and reposition R2 frequently during the day, 12:00 a.m. and 4:00 a.m. at night; turn from Side to Side: R2 required substantial/max assist of 1 staff member for turning side to side in bed with use of bilateral grab bars on bed.- During a continuous observation on 8/20/25 at 7:18 a.m., R2 was lying in bed. R2's head of bed (HOB) was approximately elevated to 30 degrees and R2's tv was on. R2's overbed table was in front of R2. R2 was rubbing her eyes and stated she was tired that morning. At 7:20 a.m., nursing assistant (NA)-E stepped into R2's room and stated R2 wanted to eat breakfast in her room that morning. NA-E requested R2's breakfast order then raised R2's HOB so R2 was sitting upright. NA-E did not offer or reposition R2 before leaving the room. At 7:42 a.m., R2's breakfast tray was delivered and set up by kitchen staff. At 8:00 a.m., NA-C stepped into R2's doorway and asked R2 if she was doing ok. R2 was eating her breakfast. NA-C did not offer or reposition R2. At 8:53 a.m., R2 continued to sit in the same position. R2's finished breakfast remained in front of her on the overbed table. At 9:46 a.m., NA-F entered R2's room and told R2 NA-F was going to check her. NA-F removed R2's breakfast tray, performed incontinence cares and transferred R2 to her wheelchair with the full body mechanical lift and NA-E.- During an interview on 8/20/25 at 9:58 a.m., NA-F stated R2 needed to be turned and/or repositioned every two to three ours.During an interview on 8/20/25 at 10:02 a.m., NA-B and NA-C stated R2 needed to be turned and repositioned every two hours. NA-B stated the electronic point of care (POC) module directed the staff when residents were due and, once completed, the nursing assistants signed it off. NA-C stated she did R2's cares that morning before 7:00 a.m. and stopped into R2's room at 8:00 a.m. to reposition R2 but R2 was eating. However, NA-C did not offer to reposition R2 nor returned to R2's room after R2 was finished eating. NA-C stated someone should have.During an interview on 8/20/25 at 11:11 a.m., registered nurse (RN)-A stated R2 was at risk for pressure injury/ulcer and the nursing assistants should have offered to turn and reposition R2 was she was done eating breakfast.During an interview on 8/20/25 at 11:31 a.m., the director of nursing (DON) stated R2 typically had morning cares between 6:00 a.m. and 7:00 a.m. R2 liked to stay in bed for breakfast and the nursing would get R2 up into her wheelchair later in the morning. The DON stated staff should have offered to turn and reposition R2 approximately a half hour after eating.During an interview on 8/20/25 at 4:26 p.m., the administrator stated he expected staff to follow policy and procedure.The facility policy revised 4/6/25, identified Residents who are unable to reposition themselves independently, as indicated on the Sit-Stand-Walk Data Collection Tool UDA, should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is required for those residents unable to position themselves and is based on nutrition, hydration, incontinence, diagnoses, mobility and observation of the resident's skin over a period of time. The Positioning Assessment and Evaluation UDA is a required tool that is used to determine an individualized repositioning plan. The positioning schedule should be communicated to the nursing assistants using the Kardex in PCC-POC. Any resident at risk will be placed on a pressure redistribution surface as determined appropriate.

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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** Based on interview and document review, the facility failed to assess and analyze a resident fall with major injury to identify specific hazards and/or risks and to develop targeted interventions to reduce the potential for falls for 1 of 1 resident (R27) reviewed for falls.Findings include:R27's resident event form dated 8/8/25 at 4:45 p.m., identified on 8/8/25 R27 was observed peddling himself with his feet in the hallway, became tangled up in a computer table and fell out of his wheelchair. The wheelchair then fell on top of the resident. No immediate intervention put into place and unknown if there was an injury. R27's progress notes dated 8/11/25 at 4:50 p.m., identified R27 had a fall on 8/8/25 with a hip fracture and was currently in the hospital after hip nailing. Anti-roll backs would be applied to resident's wheelchair. However, the note failed to identify a description or cause of R27's fall.R27's falls tool report dated 8/15/25, identified R27 was at risk for falls related to an actual fall on 8/8/25, was taking 2 or more at risk medications, had moderately impaired cognition, reduced insight, delirium, poor memory and was impulsive. However, the tool failed to identify a description of or cause of R27's fall on 8/8/25.R27's care plan reviewed 8/18/25, identified R27 required staff assistance to transfer with a non-mechanical stand aide and did not ambulate. R27 had an actual fall with major injury and safety interventions included staff to remind resident not to bend over to pick up dropped items, use call light for assistance and keep personal items within reach.R27's medical record failed to identify a comprehensive assessment following the fall on 8/8/25, to include causal factors and/or root cause of R27's in an attempt to prevent further falls. R27's Medicare 5-Day Minimum Data Set (MDS) dated [DATE], identified R27 was readmitted to the facility on [DATE], after an acute hospital stay. R27 was cognitively intact, required staff assistance with activities of daily living (ADL's), and had diagnoses including surgical repair of the right hip after a fall with major injury on 8/8/25.On 8/20/25 at 11:20 a.m., nursing assistant (NA)-E stated R27 had a fall recently when the resident reportedly fell in the lobby and fractured the right hip. Upon return from the hospital, R27 required more assistance with ADL's, couldn't stand on his own, and didn't call for help as much as previous. Staff used the manual sit-to-stand lift (a mobility aide designed to assist individuals in transitioning safely from sitting to standing) for all transfers. On 8/20/25 at 2:25 p.m., registered nurse (RN)-A stated R27 fell on 8/8/25, thought a note was entered in the EMR and remembered talking about the fall, although, upon request RN-A was unable to find documentation regarding the residents fall or discussions related to the fall. Further, RN-A stated R27's fall was not documented in the EMR.On 8/20/25 at 2:43 p.m., the DON stated the interdisciplinary team (IDT) met every Wednesday morning to discuss high risk incidents including resident falls. On 8/13/25 at 9:56 a.m., there was a note in the resident's chart identifying the IDT team met and discussed the residents fall, although the note failed to identify causal factors of the fall. The DON stated upon readmission, R27 had a fall tool was completed, although was uncertain what the assessment entailed or if the fall was assessed or analyzed to determine causal factors or a root cause. The DON stated interventions to prevent further falls included anti-roll backs on R27's wheelchair. The DON stated R27's fall was probably not documented in the medical record. The facility Fall Prevention and Management policy reviewed 4/8/25, included after stabilizing a resident from a fall with major injury, the nurse would complete a fall scene huddle worksheet, initiate an investigation into the fall, update the careplan, and document in Riskonnect. The completed fall scene huddle worksheet would be given to the fall committee chair or designee for review and follow-up.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a physician order for indwelling urinary catheter; and failed to ensure urinary catheter care was provided in a manner to prevent contamination and potential urinary tract infection (UTI) for 1 of 4 residents (R4) reviewed for urinary catheter. Findings include:R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 had a severe cognitive impairment and had diagnoses that included hematuria, neuromuscular bladder dysfunction (nerve damage that affects bladder control), reflux uropathy (the backward flow of urine from your bladder into your kidneys. Without treatment, the condition could lead to complications such as high blood pressure and chronic kidney disease.), type 2 diabetes, dementia and a methicillin resistant staphylococcus aureus (MRSA). R4 used an indwelling urinary catheter.R4's care plan revised 4/18/25, identified R4 had an indwelling catheter due to urinary retention and obstruction. Staff were instructed to:, Monitor/document for pain/discomfort due to catheter, Document intake and/or output., Monitor/document for pain/discomfort due to catheter, and Monitor/record/report to health care provider for signs/symptoms of urinary tract infection (UTI): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increasedR4's Interagency Handoff Report dated 7/8/25, identified R4 was hospitalized due to kidney stones and had ureter stents placed. R4's indwelling catheter was replaced while hospitalized on [DATE] with a 24 French (FR) foley catheter with a 60 milliliter (ml) balloon. The report failed to identify an order for continued urinary catheter use.R4's Order Summary report dated 8/21/25, identified maintain 20 FR coude catheter (a urinary catheter with a curved tip) with 30 ml balloon. Change every 14 days and as needed for obstruction at bedtime every 2 weeks related to urinary retention and obstruction was discontinued on 7/8/25.R4's nursing progress note dated 7/22/25 at 3:11 p.m., identified R4 had a follow-up Urology appointment on 7/21/25 and R4 was scheduled for further imaging of his kidneys and a follow-up Urology appointment with the provider who performed R4's procedure. The note failed to identify an order was received for continued urinary catheter use.R4's nursing progress note dated 8/3/25 at 7:52 a.m., identified R4's indwelling foley catheter was replaced with a 20 FR foley catheter with a 5 ml and urinary catheter bag falling apart. R4's prior catheter was intact but had a blood clot on the tip blocking urine flow. The note failed to identify if a provider was contacted to obtain an order for replacement.During an observation on 8/18/25 at 6:44 p.m., nursing assistant (NA)-D assisted R4 with evening cares. NA-D wore gown, and gloves. When finished, NA-D hung R4's urinary catheter bag on the bedframe and lowered R4's bed to the floor. R4's urinary catheter bag port was not fastened to the holder and the bag rested on the floor. At 6:57 p.m., NA-D removed her soiled gloves, used hand sanitizer and put on new gloves. NA-D obtained a graduate from R4's closet and placed the graduate under R4's urinary catheter bag. NA-D drained approximately 500 cc of urinary from the bag then closed and cleaned the port with an alcohol wipe. NA-D poured the graduate into the toilet and set the graduate down. NA-D removed her gloves, washed her hands, then put on new gloves. NA-D then picked up the soiled graduate and placed it back into the closet. However, NA-D did not remove her soiled gloves. At 7:03 p.m., NA-D removed R4's teeth from his denture cap and placed them in R4's mouth. NA-D removed her soiled gloves/gown and used hand sanitizer before leaving the room. However, R4's urinary catheter bag remained on the floor.During an interview on 8/18/25 at 7:09 p.m., NA-D stated she did take off her gloves and wash her hands before putting away the graduate, but did not change her gloves before assisting R4 with his dentures because she thought the outside of the graduate was clean. Also, NA-D stated she left the urinary catheter bag touching the floor and R4 needed his bed lowered for safety. NA-D stated the urinary catheter bag should not lie on the floor because the floor was dirty, and it could lead to R4 getting an infection.During an interview on 8/20/25 at 11:12 a.m., registered nurse (RN)-A stated R4 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had an order for his catheter before R4 was hospitalized but did not have a current order. RN-A stated he did see the note where R4's catheter was changed, and an order should have been obtained prior to changing. Also, when R4 returned from the hospital, the admitting nurse should have contacted R4's provider for further direction. Further a resident's catheter bag should never rest on the floor. The catheter bag should either be clipped higher or put in a cloth bag for basic hygiene and to keep the floor and catheter bag sanitary. Staff were expected to remove soiled gloves and wash hands prior to doing oral cares.During an interview on 8/20/25 at 1:19 p.m., the director of nursing (DON) stated the facility had a new policy to not flush or change a catheter unless there was a problem. R4 used to have weekly catheter changes and as needed. R4 returned to the facility with a 24 FR coude catheter and there was no order for weekly catheter changes, however, the DON was unaware R4 did not have an order for changes as needed. The staff should have ensured there was an order before changing the catheter on 8/3/25. The DON had worked the night shift on 8/3/25 and the day nurse said she could change R4's catheter and the DON went home. The DON stated she did not verify R4's orders. Further, a barrier should have been placed under R4's urinary catheter bag or the urinary catheter bag placed into a cloth bag to prevent infection. The nursing assistants are trained to removed soiled gloves and wash their hands prior to doing oral cares. During a telephone interview on 8/20/25 at 3:32 p.m., the urologist stated he had only evaluated R4 the one time postoperatively. The urologist didn't have enough data from R4's hospital stay to be able to fully care for R4. Because of that, he referred R4 back to urologist who performed R4's procedure and ordered a follow up CT to ensure they had all the possible information for that appointment. For the urinary catheter, the urologist stated he could not determine why R4 had a 24 FR coude catheter with a 60 ml balloon was placed after R4's procedure. Because of that, he would expect staff to contact the discharging physician to obtain further direction and to follow orders as given. During an interview on 8/20/25 at 4:26 p.m., the administrator stated he expected staff to follow facility policy and procedureThe facility policy Catheter Care: Insertion and Removal, Drainage Bags, Irrigation, Specimen revised 4/6/25, identified the following: Catheters will be inserted only with a physician's order and will include the type of catheter, size and balloon capacity for indwelling catheter. Catheter tubing should never be allowed to touch the floor. Non-obstructed downhill flow is always maintained. PROCEDURE Emptying Catheter Drainage Bag Equipment1. Perform beginning five and apply gloves.2. If splashing or spraying is anticipated use personal protected equipment (PPE).3. When emptying the catheter bag, place a fluid-impermeable pad beneath the measuring container and avoid placing the container on the floor.4. Open drainage port and allow urine to drain into measuring container placed underneath. Do not allow tip of tubing to touch sides of the measuring container or any surface.5. When done, clean drainage port tip with alcohol wipe and replace in the holder.6. Make sure the drainage bag and tubing are appropriately placed.7. In rehabilitation/skilled care, if resident is on Intake and Output measure urine volume and record in PCC-POC/EMR.8. Discard urine in toilet.9. Wash and dry measuring container according to location procedure. Do not store the measuring container on the floor.10. Perform ending five.11. Note amount and character of urine. Report any significant observations to licensed nurse (blood, mucous, low urine output).

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	08/20/2025

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the consulting pharmacist recommendations were addressed and acted upon and documented in the medical record for 2 of 5 residents (R26, R7) reviewed for unnecessary medications.Findings include: R26's quarterly Minimum Data Set (MDS) dated [DATE], identified R26 had a moderate cognitive impairment and had diagnoses that included dementia. R26 used antidepressant medication daily. R26's Order Summary Report dated 8/21/25, identified Trazodone HCl oral tablet (an antidepressant primarily used to treat major depressive disorder. It works by increasing serotonin levels in the brain, which can help improve mood, appetite, and energy levels, as well as reduce anxiety and insomnia related to depression. Additionally, trazodone is sometimes prescribed as a sleep aide due to its sedative effects, and it is considered non-addictive.) give 25 milligrams (mg) at bedtime related to unspecified dementia, moderate, with other behavioral disturbance was started on 1/28/25. R26's Consultant Pharmacist's Medication Review dated 7/11/25, identified R26 was prescribed Trazodone 25 mg at bedtime since 1/28/25. Per CMS guidelines, all psychotropic medications should be considered for a trial dose reduction at least twice within the first year of use. If a dose decrease is contraindicated, rigorous risk/benefit documentation should be provided. A review of recent provider progress notes did not yield a thorough risk/benefit assessment for this patient's psychotropic medications. Suggested course of action: Please evaluate the above psychotropic medications and consider reducing either the trazodone dose on a trial basis or provide clear clinical documentation as to why a dose reduction is contraindicated at this time. However, the form failed to identify a response from R26's physician. R26's medical record failed to identify R26's provider was contacted regarding R26's Trazodone and/or pharmacist's recommendations. During an interview on 8/20/25 at 11:28, the director of nursing (DON) stated she believed she missed R26 had an appointment with his physician, or she would have requested R26's Trazodone be discontinued. The DON preferred as many medication requests were done during appointments as possible because faxed requests usually did not generate a response. During an interview on 8/20/25 at 3:44 p.m., the consultant pharmacist stated, in general, after a resident was taking Trazodone for 6 months, a gradual dose reduction (GDR) was recommended. During an interview on 8/20/25 at 4:26 p.m., the administrator stated he expected staff to follow facility policy and procedure. R7's quarterly MDS dated [DATE], identified R7 had moderate cognition. Diagnoses included obsessive-compulsive disorder (mixed obsessional thoughts and acts), dementia, anxiety, depression and psychotic disorder. R7 received antipsychotics on a routine basis, a gradual dose reduction (GDR) had not been attempted or had not been documented by a physician as clinically contraindicated. R7's physician orders identified an order for olanzapine (antipsychotic medication) to be given twice daily related to depression and was started 1/19/23. R7 also received Sertraline given one time a day (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for depression with psychotic symptoms and was started 6/5/22. R7's Consultant Pharmacist's Medication Review, dated 6/6/25, identified Olanzapine 5 mg tablet take 1 tablet by mouth twice a day. This patient has been prescribed olanzapine since 1/20/22 and continued Sertraline 125 mg per day. Per Centers for Medicare and Medicaid Services (CMS) guidelines, all psychotropic medications should be considered for a trial dose reduction at least twice within the first year of use. If a dose decrease is contraindicated, rigorous risk/benefit documentation should be provided. A review of recent provider progress notes indicated R7 was followed by psychiatry for management of these medications, however, the most recent Psychiatry note on file in R7's electronic medical record (EMR) was 7/30/24, and while it stated to continue olanzapine 5 mg twice daily and Sertraline 125 mg daily, it does not include a thorough risk/benefit assessment for R7's psychotropic medications. Suggested course of action: if R7 was seen Psychiatry since the visit on 7/30/24, please obtain a copy of the progress note and file to the EMR, making sure that they addressed the ongoing need for the current psychotropic medications (why a dose reduction is clinically contraindicated). If R7 had not seen psychiatry since last July, consider scheduling a visit to have the provider assess the patient for a potential gradual dose reduction or if no longer followed by psychiatry, please have the primary evaluate R7 for a gradual dose reduction. Implementation time frame: nursing staff to address as soon as possible (ASAP) but no later than 30 days. R7's medical record lacked evidence a GDR had been attempted or identified a medical justification the resident was on the lowest effective dose within the past calendar year, or that the pharmacy recommendation had been followed up on. On 8/20/25 at 3:33 p.m., the director of nursing (DON) stated R7's last psychology visit was more than a year ago and had failed previous attempts for GDR's, however, the DON couldn't remember when GDR was attempted or if they were documented in R7's medical record. The DON stated she expected GDR's to be attempted or documented contraindications to be done yearly. On 8/20/25 at 4:21 p.m., a message was left for the consulting pharmacist requesting return call. The facility Psychotropic Medications policy reviewed 5/12/25, identified the consulting pharmacist would review resident medication records monthly for documentation/justification for the drug use and will recommend dosage reductions or modifications as appropriate. The facility policy Medication: Drug Regimen Review revised 12/2/24, identified a drug regimen review is performed for each resident at least once a month by a licensed pharmacist. This review must include a review of the residents' medical chart. The pharmacist will complete a written report noting any drug irregularities or issues of concern for each resident reviewed. The pharmacist will also complete the Medication Regimen Review Summary for QAPI Committee document. Both reports will be given to the director of nursing services upon completion of each monthly DRR. The reports must be shared with the attending physician and the location's medical director, and these reports must be acted upon. Should the consultant pharmacist detect a potential or actual problem that requires urgent action to protect the resident, he or she will promptly alert the direct care nurse for immediate action. If prescriber intervention is required, the consultant pharmacist will ensure proper communication is provided to the attending physician, nurse practitioner or physician's assistant to ensure resolution by midnight of the next business day. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Drug irregularities will be reported to the medical director and attending physician by the director of nursing services or designee. The location must designate someone to ensure that these reports have been acted upon within 30 calendar days of the review and have been documented. Regarding psychopharmacological medications, the location will ensure that residents who have not used psychopharmacological medications and sedative/hypnotics are not given these unless this therapy is necessary to treat a specific condition, as diagnosed and documented in the medical record. In addition, those residents who do use these types of medications will receive gradual dose reductions or behavioral interventions, unless clinically contraindicated, in an effort to discontinue the drugs.