Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 4, 2025

Administrator
Good Samaritan Society - St. James
1000 SOUTH SECOND STREET
ST JAMES, MN 56081

RE: CCN: 245593
Cycle Start Date: May 29, 2025

Dear Administrator:

On July 11, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered

August 4, 2025

Administrator
GOOD SAMARITAN SOCIETY - ST JAMES

1000 SOUTH SECOND STREET
ST JAMES, MN 56081

Re: Reinspection Results
Event ID: 7RFF12

Dear Administrator:

On July 11, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 29, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 23, 2025

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

RE: CCN: 245593
Cycle Start Date: May 29, 2025

Dear Administrator:

On May 29, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 29, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 29, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/27/25-5/29/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/27/25-5/29/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55935508C (MN00112387) with a deficiency cited at F580. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		7/9/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/02/2025

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.

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F 580	Continued From page 1 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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F 580	Continued From page 2 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the resident representative and the medical provider following a fall with potential injury for 1 of 1 resident (R132) reviewed for notification of change. Findings include: R132's face sheet printed on 6/10/25, included diagnoses of dementia with agitation, psychosis and anxiety, and delusional disorder. R132's significant change Minimum Data Set (MDS) assessment dated 1/23/25, indicated R132 had severe cognitive impairment, unclear speech, was sometimes understood and could sometimes understand. R132 had frequent behaviors such as pacing and rummaging. R132 required supervision, partial assistance or was dependent on staff for activities of daily living. R132 could walk independently. R132's physician orders dated 2/27/25, indicated hospice order for evaluation and treat. R132's nursing order dated 2/6/25, indicated have staff walk R132 at least twice a shift every 4	F 580	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F580 Notify of Changes (Injury/Decline/Room etc.) 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 132 has deceased. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified?	

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F 580	Continued From page 3 hours related to dementia. R132's care plan included focus areas of: risk for falls related to incontinence, psychoactive drug use and wandering dated 12/3/23; terminal prognosis due to dementia and on hospice care dated 1/19/24, and impaired cognition related to dementia, revised date 11/6/24. During a telephone interview on 5/22/25 at 2:52 p.m. family member (FM)-C stated R132 fell the evening of 3/5/25, and FM-C was not notified. R132 fell again the morning of 3/6/25, and FM-C was notified. The nurse who called to inform FM-C told her this had been R132's second fall in two days. That was how FM-C learned of the first fall on 3/5/25. FM-C stated R132 had been in a lot of pain in his left leg after the falls. R132 subsequently passed away on 3/9/25, four days after the first fall. During a telephone interview on 5/28/25 at 6:51 p.m., FM-C stated no one had asked her, with R132's increasing leg pain, if she would want R132 to have an x-ray to determine if there had been a fracture. FM-C added, "they said they contacted hospice and would monitor him because he couldn't walk and would give him morphine" (a narcotic pain medication). Progress note dated 3/5/25 at 2:03 a.m., indicated R132 was found on floor shortly after power went out (due to city power outage). Possibility of resident falling due to having no light. Tried assessing vitals and neuros (neurological status) while resident was on ground, but resident kept trying to get up. Resident was moved from floor to bed via Hoyer (mechanical lift) with help of nursing assistant	F 580	All residents have the potential to be affected. Facility ensured all needed providers and responsible parties were notified of every fall since March 2025 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Nurses educated on when they are to notify providers and representatives for changes/falls utilizing the Notification of Change policy. Management was also educated on this policy so they can help ensure notifications are made. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Review all falls for the week to check that provider and representatives were informed of fall. Audit weekly x 4. Then audit 5 residents a month monthly x 3. Results will be brought to QAPI for the recommendation of continuation of audit. 5. What is the date of completion? 7/9/25	

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F 580	Continued From page 4 (NA). Resident did wince when left leg was touched. Progress note dated 3/5/25 at 2:09 a.m., indicated the administrator and DON (director of nursing) notified through text message. Information sheet filled out for certified nurse practitioner (CNP)-D. Resident's family will be notified during business hours. (There was no follow up documentation indicating FM-C was notified). Progress note dated 3/5/25 at 9:05 p.m., indicated hospice was called and updated on fall from late last night. Updated on use of morphine for pain/discomfort. Unable to bear weight on LLE (left lower extremity), required assist of two to transfer into bed. Hospice progress note dated 3/5/25 (no time noted), by hospice triage registered nurse (RN) indicated: Patient fell. Having some hip pain. Advised hospice recommends least invasive treatment and to defer to patients POA (power of attorney) for course of treatment. Progress note dated 3/6/25 at 9:10 a.m., indicated R132 was found on floor sitting beside bed, moaning of pain in left hip area; resident grabbed hip. Progress note dated 3/6/25 at 5:09 p.m., indicated hospice was notified to update them that resident is still not putting any weight on LLE. Resident says he's in pain, but that's the only information you can get out of resident. Hospice said to keep up with morphine PRN (as needed) and they will be sending out a nurse to come see resident.	F 580		

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F 580	Continued From page 5 Hospice progress note dated 3/6/2025 (no time noted), indicated (RN)-D who was a hospice nurse, was at facility for a post-fall visit. Facility nurse reports R132 had a fall last night at 9:00 p.m., that was unwitnessed. After fall, according to [hospice] triage, it was reported R132 was having trouble bearing weight and having right lower extremity pain and was given prn morphine. R132 was not transported to the hospital according to facility nurse. Facility nurse reports R132 was requiring a two-person transfer after fall. Facility nurse reports R132 had another fall this morning after breakfast that was a non-witnessed fall. R132 was helped back to bed, given morphine, which was effective and prn O2 (oxygen) was applied due to saturations in the 60's. R132 was observed resting in bed with O2 on via nasal cannula at 2 liters per minute. R132 was keeping the O2 on which was out of the ordinary. R132 was not responsive to voice or touch which was his baseline when sleeping. R132 continued to have full body involuntary movements where his whole body would twitch. R132 appeared very comfortable. Spoke to FM-C who reports she was not aware of the fall last night until just now; she would like to schedule morphine at this time to try to keep him comfortable and perhaps dissuade R132 from trying to get up again today. Progress note dated 3/6/25 11:51 a.m., indicated IDT (interdisciplinary team) met to review incident of R132 trying to ambulate in the dark and fell. Will get R132 a night light that has battery powered back up for if the lights go out. Progress note dated 3/6/25 at 9:01 p.m., indicated staff not able to carry out nursing order	F 580		

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F 580	Continued From page 6	F 580		

to walk R132 at least twice a shift due to recent fall as R132 not unable to bear weight on left leg.

Progress note dated 3/7/25 dated 12:32 a.m., indicated staff not able to carry out nursing order to walk R132 at least twice a shift due to no weight bearing on left hip.

Progress note dated 3/8/25 at 8:20 p.m., indicated R132 had remained in bed throughout the shift. Knees were bent, opening slowly, and then quickly closed continuously. Has received scheduled and prn MS (morphine) and prn Ativan (anti-anxiety medication). Receiving O2 via a mask due to mouth breathing. Has not exited his bed.

Progress note dated 3/9/25 at 5:00 a.m., indicated R132's condition was poor. In the dying process. MS (morphine) and lorazepam (anti-anxiety medication) given as ordered but has difficulty swallowing. Comfort measures done. Mouth care. Has been incontinent of urine several times. Turned and repositioned for comfort.

Progress note dated 3/9/25 at 8:02 a.m., and identified as a late entry indicated spoke to FM-C about R132's condition and if they would want to come sit with him as his condition was deteriorating more quickly.

Hospice progress note dated 3/9/25, (no time noted), family present at bedside. Facility reports pt has not eaten since fall on Tuesday (3/6/25) and has only tried to get out of bed once. Observed nonresponsive in bed with oxygen on. Mouth breathing. No periods of apnea (temporary cessation of breathing) noted. Respirations are

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F 580	Continued From page 7 somewhat agonal (last gasps). Discussed with family signs and symptoms of end of life. They appear to be coping well and prepared for this. Pt appears comfortable and not in distress. Discussed protocol with facility for when pt passes. Progress note dated 3/9/25 at 8:05 a.m., and identified as a late entry indicated hospice was notified of residents failing state of health and will come to assess resident condition. Resident passed after hospice nurse left, and she was to be notified of his passing to call the funeral home and details. Progress note dated 3/9/25 at 13:51 p.m., indicated on-call nurse practitioner was updated on death and received order to release residents body. During an interview on 5/29/25 at 7:39 a.m., registered nurse (RN)-A stated R132 had pain after his falls and thought he had an x-ray. While looking for documentation in the EMR (electronic medical record) for an x-ray, RN-A found a fax communication dated 3/6/25 at 10:30 a.m., from the facility to certified nurse practitioner (CNP)-D which indicated R132 was found on the floor at 9:10 a.m. Left hip pain and moaning. Vital signs within normal limits. Skin assessment done. Oxygen applied. CNP-D informed the facility to follow up if problems weight bearing and increased pain. RN-A did not know if or how that order would have been shared with all nurses if they had not seen the fax. No order had been entered into the EMR to prompt nurses to monitor R132's weight bearing and pain, and to notify CNP-D.	F 580		

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F 580	Continued From page 8 During an interview on 5/29/25 at 9:14 a.m., CNP-D reviewed the fax communication dated 3/6/25 at 10:30 a.m. CNP-D states she did not recall being informed R132 was having increased pain and problems with weight bearing as she had ordered staff to do. CNP-D stated had staff informed her R132 had not been bearing weight and had increased pain, she would have ordered an x-ray, then talked to the family to ask if they agreed. If they agreed, the x-ray was ordered, if they did not want an x-ray, the order would be canceled. CNP-D stated it would have at least initiated a conversation. CNP-D acknowledge the fall, and potentially undetected fracture could have hastened his death, stated, "Yes, it could have contributed to it. R132 was very thin and had no cushion, so there was a high chance he had a fracture." During an interview on 5/29/25 at 9:53 a.m., the director of nursing (DON) and the administrator were asked about the following events: 1. Was 132's family notified of the fall on 3/5/25, at approximately 2:00 a.m.? Progress notes dated Monday 3/5/25, at 2:09 a.m., indicated, "residents family will be notified during business hours." There was no documentation in the EMR to indicate family was notified. The DON stated staff usually notified family no matter what time of day an event occurred. The administrator stated FM-C had been informed after the second fall. 2. Did the nursing staff follow CNP-D order to follow up with her if R132 had problems weight bearing and increased pain? The DON stated the staff would have notified hospice. The DON was asked if staff would call hospice even though the order came from CNP-D. The DON stated she found it hard to believe staff did not follow up with	F 580		

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F 580	Continued From page 9 CNP-D and stated she would look for that documentation. The DON and administrator stated they were unaware R132 had been having increasing difficulty bearing weight and having increased pain. 3. FM-C was not given opportunity to decide if R132 should have an x-ray to determine if a fracture occurred after the falls. The DON stated FM-C had been given that opportunity. The DON was asked for that documentation. The DON provided a document titled Nursing Home Scheduling, which was a form prepped by the facility to indicate names of residents who should be seen during a provider visit. This document was dated 3/6/25, and did not include R132. The DON acknowledged this would have been an opportunity to request CNP-D to see R132. The DON did not know why R132 had not been added to this schedule. An email received from the DON dated 5/30/25 at 2:56 p.m., indicated no documentation had been found indicating FM-C has been notified of R132's fall on 3/5/25. No documentation was found indicating CNP-D had been notified of R132's problems bearing weight and his increasing pain. Facility Notification Of Change policy dated 12/23/24, indicated a facility must immediately inform the resident, consult with the resident ' s physician and notify, consistent with his or her authority, the resident representative(s) when there is: 1) An accident involving the resident which results in injury and has the potential for requiring physician intervention. 2) A significant change in the resident ' s physical, mental or	F 580		

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F 580	Continued From page 10 psychosocial status. 3) A need to alter treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		7/9/25

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F 656	Continued From page 11 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive care plan was developed and maintained for 1 of 1 resident (R2) reviewed reviewed for constipation. Findings include: R2's diagnosis report printed on 5/29/25, included dementia, and encounter for palliative (comfort) care. R2's quarterly Minimum Data Set (MDS) assessment dated 3/8/25, indicated severely impaired cognition, unclear speech, rarely understands or is understood and has severely impaired cognitive skills for daily decision making. R2 was dependent on staff for all activities of daily living (ADL's). R2 was receiving hospice services. R2's physician orders included Senna-S (laxative) tablet 8.6-50 mg (milligrams) dated 7/17/24; Give 1 tablet by mouth one time a day; may give two	F 656	F656 Develop/Implement Comprehensive Care Plan 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 2 had a new bowel and bladder assessment completed and her care plan was updated to reflect her current status. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be affected. Facility ensured every resident had an updated bowel and bladder assessment completed and that their care plan reflected these results. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Nurse management educated on the Bowel and Bladder assessment and the importance of ensuring this aspect of their	

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F 656	Continued From page 12 tablets every 24 hours as needed for constipation. May give up to twice daily as needed. Contact provider/practitioner if there are 3 days without a significant BM. Additional physician orders dated 9/10/24, included dulcolax suppository 10 mg every 6 hours as needed for constipation. Contact provider/practitioner if there are three days without a significant BM. An order from Hospice dated 5/11/25, included give dulcolax suppository every other day. R2's Care Area Assessment dated 12/9/24, included urinary incontinence but did not include bowel issues. R2's care plan with revised date of 1/1/25, did not include care plan for incontinence of bowel or bladder or constipation or bowel issues. The care plan did include multiple other care areas including hospice, opioid use and pain management. On interview 5/27/25 at 2:00 p.m., family member (FM)-B stated R2 ended up in the emergency room (ER) because she hadn't "pooped in days". FM-B stated on her daily visit, she knew her mom was uncomfortable by her facial grimacing and staff told her she hadn't had a BM in multiple days. Record review identified R2 had no documented BM for 4/1/25 to 4/5/25; 4/8/25 to 4/18/25; 4/19/25 to 4/29/25; 4/30/25 to 5/5/25, 5/8/25 to 5/13/25; 5/19/25 to 5/22/25; 5/23/25 to 6/1/25. During an observation 5/28/25 at 9:39 a.m., R2	F 656	care plan remains up to date. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Review 5 residents□ bowel and bladder care plan every week to ensure their plans are up to date. Audit weekly x 4 then monthly x 3. Results will be brought to QAPI for the recommendation of continuation of audit. 5. What is the date of completion? 7/9/25	

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F 656	Continued From page 13 was transferred from her Broda (positioning) chair to her bed with use of lift and nursing assistant (NA)-A and NA-E. R2's incontinence pad was wet with no BM. Staff changed the pad, performed perineal care, placed a new pad and positioned R2 in the bed. R2 was non verbal. NA-A and NA-E indicated R2 can not verbalize pain but you can tell by her facial expressions and change in behavior when she is in pain and they report that to the nurse. On interview 5/28/25 at 1:35 p.m., registered nurse (RN)-A stated each resident is different on the amount of days they can go without a BM. RN-A stated R2 should have a plan of care to address her constipation issues especially since being on opioids which can cause constipation. On interview 5/29/25 at 11:45 a.m., the director of nursing (DON) confirmed the care plan lacked a plan to address R2's constipation issues and she should have one. Facility Bowel and Bladder: Evaluation, Assessment, Toileting Programs policy dated 5/7/25, included: - Care plan interventions should be individualized based on the CAA assessment and modified as appropriate based on an assessment/evaluation of the resident ' s response to the interventions and success with attaining/maintaining bowel continence. Any alteration of elements of the program should be made one at a time. Examples that may be tried for a week include: · Suppository frequency · Number of suppositories · Diet · Fluid volume	F 656		

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F 656	Continued From page 14 · Activity · Medication -Modify one element of the program as suggested and add to care plan. -Use focuses/goals/interventions from the the EMR library to care plan bowel function/status interventions. Facility Comprehensive Care Plan and Care Conferences policy dated 1/31/25, included: Formulating the Care Plan - The care plan is driven by identified resident issues/conditions and their unique characteristics, strengths and needs. When implemented in accordance with standards of good clinical practice, the care plan becomes a powerful, practical tool representing the best approach to providing quality of care and quality of life. -The focus includes: The identified problem or strength. What the problem is related to (r/t) (what you feel is contributing to the problem). This usually is a diagnosis, event or occurrence. What the problem is evidenced by (e/b) (what you see or hear the resident doing that tells you there is a problem, need or concern). Use language easily understood by all employees. Note: If the focus is a "potential for," the care plan may not need an evidenced by statement. -Problems/needs/concerns/strengths may be combined on the care plan as long as individual needs are addressed.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		7/9/25

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F 657	Continued From page 15 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have an admission or quarterly care conference or invite and/or involve the resident and/or family representative to participate in their quarterly care conference for 3 of 3 residents (R26, R3, and R4) reviewed for care planning. Findings include:	F 657	F657 Care Plan Timing and Revision 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R26, R3 and R4 and their representatives were offered a care conference. 2. How will other residents, having the potential to be affected by the same	

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F 657	Continued From page 16 R26's Admission Record indicated admission to the facility on 1/9/25. R26's significant change Minimum Data Set (MDS) assessment dated 3/4/25, indicated R26 was cognitively intact, required substantial/maximal assistance with walking, toileting, and transfers. Diagnosis included osteomyelitis (bone infection), ileostomy status (surgical procedure that creates an opening in the abdomen for the ileum (the last part of the small intestine) to exit, allowing waste to be collected in an external pouch), sepsis (blood infection), and cystitis (inflammation of the bladder caused by urinary tract infection). R26's care plan dated 2/25/25 and last revised 5/20/25, included multiple care areas related to activities of daily living (ADLs), pain management and disease processes. R26's electronic medical record (EMR) did not include a care conference meeting note or that R26 was included in development and revisions of the plan of care. On interview 5/27/25 at 11:28 a.m., R26 stated she has not had any care conference meetings since being at the facility nor have they asked about her input for her care plan. R26 stated she is going home at the end of the week. On interview 5/28/25 at 1:53 P.M., R26 confirmed she has not had any care conference meetings since being at facility and was not involved in her care plan development. R26 stated she was surprised she hasn't had one as she was always involved with her mother's care conferences	F 657	deficient practice, be identified? All residents have the potential to be affected by this. Facility ensured all current residents have received a care conference this past quarter, a care conference calendar has been created and all new admissions moving forward will be added to the calendar upon admission. Each family/representative will receive a letter offering them a care conference. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? All management staff educated on care conferences following the Care Plan and Care Conference Policy. Management staff also educated on the new care conference calendar created by our social worker and when it is to be updated. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Audit that each care conference required for the week took place. Audit weekly x 4. Then audit 5 care conferences a month, monthly x 3. Results will be brought to QAPI for the recommendation of continuation of audit. 5. What is the date of completion? 7/9/25	

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F 657	Continued From page 17 when she was a resident. On interview 5/28/25 at 2:16 p.m., social service director (SSD)-A confirmed R26 has not had a care conference since she has been at the facility. SSD-A stated R26 should have had at least one care conference but added she had met with the resident and a family member but that did not include other team members. R3's Admission Record indicated admission to the facility on 7/2/24, with diagnoses including heart failure, dementia and major depressive disorder. R3's quarterly MDS dated 4/20/25, indicated moderate cognitive impairment, but usually understands and is understood. R26 had no behaviors, is on scheduled pain medications rating pain at 7 on scale of 1-10, and is on medications including opioid, antidepressant, anticonvulsant, antiplatelet and diuretic. R3 also has had one fall and requires partial to moderate assist with activities of daily living. On interview 5/27/25 at 1:38 p.m., R3, using interpreter service, stated they have never invited him to a care conference and he has not had any input into his plan of care at the facility since he has been here. Review of the electronic medical record (EMR) included a Care Conference on 4/16/25, which indicated 2 staff attended and R3 was invited but chose not to attend. The EMR lacked evidence of other care conferences. On interview 5/28/25 at 2:16 p.m., SSD-A stated R3 had a care conference initially but none since	F 657		

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F 657	Continued From page 18	F 657		

that time. SSD-A stated the facility had multiple people missing that generally attend care conferences so were not able to get the care conferences completed and were aware they were not in compliance.

On interview 5/29/25 at 11:29 a.m., the director of nursing (DON) stated care conferences should happen within the first 21 days the resident is at the facility and then quarterly after that.
R4's face sheet received on 5/29/25, included diagnoses of heart failure, high blood pressure, and chronic kidney disease.

R4's quarterly MDS assessment dated 4/29/25, indicated intact cognition, clear speech, could understand and be understood. R4 was independent or required supervision with ADLs.

R4's care plan initiated 1/27/25, included multiple focus areas, goals and interventions. The care plan did not include care conferences.

R4's care conference progress note dated 5/14/25 at 10:43 a.m., indicated staff and family member (FM)-A were present. Nursing reported on health and went over the medication. Increase weight was discussed. Family wants her treated only at the nursing home and not the hospital. Dietary reported on intake and weight. Code statue was reviewed, and remains a DNR (do not resuscitate). Family was given a copy of the care plan. Social worker reported on assessments and participation [in activities].

During an interview on 5/27/25 at 3:19 p.m., R4 and FM-A stated since R4's admission in January (1/21/25), R4 had only one care conference and that was a couple of weeks ago. FM-A stated she

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F 657	Continued From page 19 was aware the social worker had been out of work for a while. During an interview on 5/28/25 at 3:27 p.m., SSD-A stated she was responsible for arranging and facilitating care conferences. SSD-A stated on 1/29/25, she had been getting ready to conduct multiple resident care conferences, including R4's when she became incapacitated and the care conferences that were scheduled that day where not done nor rescheduled. During an interview on 5/29/25 at 10:39 a.m., the DON and administrator were informed R4 had not had an initial care conference after admission in January due to SSD-A not being able to conduct them on 1/29/25. Informed R4's first and only care conference was on 5/14/25. The administrator thought the 1/29/25, care conferences had been rescheduled and would look for documentation. An email from the administrator dated 5/29/25 at 11:23 a.m., indicated unable to find documentation of an initial care conference, or talking with R4's family in the beginning of her stay. Facility Comprehensive Care Plan and Care Conferences policy dated 1/31/25, indicated the purpose was to provide an ongoing method of assessing, implementing, evaluating and updating the resident's care plan to help maintain the resident's highest practicable level of function. The social worker would establish the time and place to hold the care conference. Residents and their representative would be invited at least two weeks in advance of the care conference. If resident and/or representative were not invited to	F 657		

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F 657	Continued From page 20 the care conference, an explanation would be included in the medical record. Residents and representatives would be informed of the right to request meetings, request revisions to the care plan and to be informed in advance of changes to the care plan. Residents had the right to see the care plan and to sign the care plan after significant changes were made. If the resident requested to sign the care plan, print a signature page and the care plan from PCC (Point Click Care, electronic medical record). The social worker would function as the facilitator during the care conference, keeping the meeting on task and making certain that residents and/or their representatives had an opportunity to voice any concerns. The social worker would facilitate the discussion of the resident's care plan and summarize the changes since the last interdisciplinary team review.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...	F 676		7/9/25

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F 676	Continued From page 21 §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based of observation, interview, and record review, the facility failed to assist with personal hygiene (oral care, shaving) as directed by the plan of care for 2 of 2 resident (R12, R25) reviewed for activities of daily living (ADLs). Findings include: R12's face sheet provided on 5/29/25, included diagnoses of chronic kidney disease and high blood pressure. R12's significant change Minimum Data Set (MDS) assessment dated 5/9/25, indicated R12 had intact cognition, clear speech, could understand and be understood. R12 required assistance with most ADLs. For oral care, the	F 676	F676 Activities of Daily Living 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Grooming services were offered and given to R12 and R25. 2.How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be affected. Ensured every current resident had been offered grooming services. Also ensured every resident who needs assistance with ADLs had it reflected in their care plans. This was completed 7/8/25.	

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F 676	Continued From page 22 MDS indicated: set up, clean-up assistance; helper sets up and cleans up; resident completes activity. R12's care plan dated 4/11/25, indicated R12 had an ADL self-care performance deficient related to recent hospitalization as evidenced by weakness and needing rehabilitation. R12's care plan did not include assisting R12 with oral care on a routine and regular basis. R12's Kardex (a reference point in the electronic medical record for nursing staff that provides a summary of a residents care and serves as a documentation tool) printed on 5/29/25, indicated in a section titled AM/PM Care: adjust provision of ADLs to compensate for R12's changing abilities. Encourage participation to the extent R12 wishes to participate. Oral care was not specifically addressed in the Kardex. R12's electronic medical record (EMR), under the TASK tab, was an assignment titled Oral Care. The question staff were to document was, "was oral care provided." Out of 60 opportunities in the past 30 days for R12 to be assisted with oral care (morning and evening), there was only one entry dated 5/18/25, at 8:55 p.m., documented as "refused." During an interview on 5/27/25 at 1:32 p.m., R12 stated, "I never brush my teeth," adding he never asked staff to help him brush his teeth and they didn't ask him. R12 stated everyone was in a hurry to get residents to breakfast in the morning. R12 stated no one offered to help brush his teeth before going to bed either. During an observation on 5/28/25 from 9:08 a.m.,	F 676	3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Ensured every CNA was educated to offer these services every shift, at the CNA skills fair June 26th or 27th. Every CNA was also educated on offering these services by receiving and reviewing the Activities of Daily Living policy. 4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Review that all residents on one hallway a week to ensure they□ve received grooming services x 6 weeks. Then 5 residents a month, monthly x 3. Results will be brought to QAPI for the recommendation of continuation of audit. 5.What is the date of completion? 7/9/25	

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F 676	Continued From page 23 to 9:30 a.m., observed nursing assistant (NA)-A provide morning cares, including assisting R12 out of bed and into the bathroom using walker, assisting R12 to sit on the toilet, switched R12's urinary drainage bag to a leg bag, changed his shirt, gave him a warm wash cloth to wash hands and face, wiped buttocks and apply a new brief, combed R12's hair and gave him his eye glasses. At 9:30 a.m., NA-A escorted R12 to the dining room via wheelchair. Oral care was not offered. During an observation and interview on 5/28/25 at 2:10 p.m., R12 was resting in his recliner. Stated no one had helped brush his teeth, and stated he supposed he should brush his teeth. Observed tooth brush in a plastic disposable emesis basis in the cupboard in R12's bathroom. Toothbrush appeared dry; no residual water in basin. During an observation on 5/29/25 at 8:44 a.m., in his bathroom, observed R12's toothbrush appeared to be dry; no residual water in emesis basin. During an interview on 5/29/25 at 9:01 a.m., NA-B verbalized the care she provided to R12 that morning but did not verbalize oral care or brushing teeth. When asked if she assisted R12 to brush his teeth, she stated, yes. NA-B stated she dried the toothbrush with a towel so it wouldn't stain the plastic disposable emesis basin. During an interview on 5/29/25 at 9:05 a.m., R12 stated no one had helped him brush his teeth yet and stated he would like his teeth brushed, adding, I probably have bad breath. During an interview on 5/29/25 at 10:31 a.m., the	F 676		

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F 676	Continued From page 24 director of nursing (DON) and administrator were informed of findings, including interviews, observations and document review. The administrator stated NA's had talked to her about this and told her they definitely did R12's oral care today. The DON and administrator were informed R12 was admitted on 4/11/25, and in the past 30 days, there had been only time where oral hygiene was documented and that was a refusal on 5/18/25. The administrator stated, that is why we tell staff they need to document. R25's face sheet printed 5/29/25, indicated diagnoses of chronic kidney disease, depression, morbid obesity, and diabetes mellitus type II. R25's quarterly MDS assessment dated 5/23/25, indicated intact cognition, no rejection of care, use of wheelchair, and partial/moderate assistance with personal hygiene which included shaving. R25's care plan dated 10/7/24, indicated ADL self-care performance deficit related to impaired mobility, pain, incontinence, and fatigue. Care plan further indicated R25 required setup assistance for personal hygiene. During interview and observation on 5/27/25 at 1:22 p.m., R25 had visible chin hair. R25 state she would prefer chin hair shaved and didn't like how long it was. R25 stated she could not always stand up to look in the mirror. During interview and observation on 5/28/25 at 3:42 p.m., R25 still had long chin hair. R25 stated she was unsure if she had a razor, and no one had offered to assist her with shaving this morning with morning cares. R25 further stated she sometimes asked staff to help her shave her	F 676		

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F 676	Continued From page 25 chin, but they would say they were too busy. R25 stated the chin hair really bothered her. During interview on 5/29/25 at 9:22 a.m., NA-B stated R25 had never had a razor and she had not told a nurse because she would get busy and forget, so she had not been able to shave her. NA-B further stated she knew R25 wanted to be shaved. During interview on 5/29/25 at 9:26 a.m., registered nurse (RN)-A stated she noticed a few days ago R25 needed her chin shaved and was going to trim it but it had slipped her mind. RN-A stated she did not know R25 did not have a razor and would have to work on getting her one. During interview on 5/29/25 at 10:19 a.m., DON stated she was unaware R25 had long chin hair or that she did not have a razor in her room. DON stated she would expect R25 to be shaved if that was her preference. Facility Activities of Daily Living policy dated 12/23/24, indicated the purpose was to provide residents with appropriate treatment and services to maintain or improve abilities in ADLs for the well-being of mind, body, and soul. Any resident who was unable to carry out ADLs would receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. ADLs were those necessary tasks conducted in the normal course of a resident's daily life. Included in these are the following: 1. General Personal, Daily Hygiene/Grooming: Care of hair, hands, face, shaving, applying makeup, skin, nails, and oral care	F 676		
F 684 SS=E	Quality of Care	F 684		7/9/25

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F 684	Continued From page 26 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement bowel movement (BM) orders or notify the provider for 1 of 1 resident (R2) reviewed for constipation. In addition the facility failed to to administer eye drops according to professional standards of practice for 2 of 3 residents (R7, R133) reviewed for medication administration. In addition, the facility failed to comprehensively assess and monitor significant bruising and a contusion for 1 of 1 resident (R4) reviewed for non-pressure skin conditions. Further, the facility failed to perform quality controls on glucometers used to assess resident blood glucose for 1 of 3 residents (R7) reviewed for insulin. Findings include: Constipation R2's diagnosis report printed on 5/29/25, included dementia, and encounter for palliative (comfort) care. R2's quarterly Minimum Data Set (MDS) assessment dated 3/8/25, indicated severely	F 684	F684 Quality of Care 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R2□s provider was notified of constipation, her hospice provider had already been notified and her care plan was updated. R7 and R133 received their next eye drops correctly. R4□s significant bruises were measured and we ensured the bruises were continuously monitored by CNAs and nurses. Quality controls were completed on R7□s glucometer. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be affected. Ensured every current resident had an up to date bowel and bladder assessment and that they received a thorough skin assessment to ensure we□re monitoring everything needed. Ensured every resident that receives eye drops received their eye drops correctly and ensured everyone□s glucometer had	

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F 684	Continued From page 27 impaired cognition, unclear speech, rarely understands or is understood and has severely impaired cognitive skills for daily decision making. R2 was dependent on staff for all activities of daily living (ADL's). R2 was receiving hospice services. R2's physician orders included Senna-S (laxative) tablet 8.6-50 mg (milligrams) dated 7/17/24; Give 1 tablet by mouth one time a day; may give two tablets every 24 hours as needed for constipation. May give up to twice daily as needed. Contact provider/practitioner if there are 3 days without a significant BM. Additional physician orders dated 9/10/24, included dulcolax (laxative) suppository 10 mg every 6 hours as needed for constipation. Contact provider/practitioner if there are three days without a significant BM. An order from Hospice dated 5/11/25, included give dulcolax suppository every other day. R2's Care Area Assessment dated 12/9/24, did include urinary incontinence but did not include bowel issues. R2's care plan with revised date of 1/1/25, did not include care plan for constipation or bowel issues. On interview 5/27/25 at 2:00 p.m., family member (FM)-B stated R2 ended up in the emergency room (ER) because she hadn't "pooped in days". FM-B stated the ER didn't do anything because R2 is on hospice services. FM-B stated on her daily visit, she knew her mom was uncomfortable by her facial grimacing and staff told her she hadn't had a BM in multiple days.	F 684	a quality control completed. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? All needed staff were educated on when to notify providers via our Notification of Change policy. Nurse management was educated on our Bowel and Bladder policy to ensure bowel and bladder care plans remain up to date. TMAs were educated on how to administer eye drops correctly by following the Medication Administration, Eye competency skills check. Nurses were educated on the need to measure significant bruises and continue monitoring these bruises by following our Skin Assessment Pressure Ulcer Prevention and Documentation Requirements policy. And nurses were also educated on when to complete quality controls on our glucometers by following our Blood Glucose Monitoring policy. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? 1. Review 5 resident□s bowel and bladder care plan to ensure their plans are up to date. Audit weekly x 4 then monthly x 3. Results will be brought to QAPI for the recommendation of continuation of audit. 2. Audit that any significant medical update of our hospice residents is being notified to both the hospice provider and the primary provider. Audit every hospice resident weekly x 4 then monthly x 3. Results will be brought to QAPI for the recommendation of continuation of audit.	

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F 684	Continued From page 28 Record review identified R2 had no documented BM for: 4/1/25 to 4/5/25; 4/8/25 to 4/18/25; 4/19/25 to 4/29/25; 4/30/25 to 5/5/25, 5/8/25 to 5/13/25; 5/19/25 to 5/22/25; 5/23/25 to 6/1/25. A physician visit dated 5/2/25 at 10:30 a.m., included no acute concerns or complaints. Bowel status "good". R2's medication administration record (MAR) indicated Senna-S tablet 8.6-50 mg was given 1 tablet by mouth one time a day April 1-30/2025 and May 1-31/25. A dulcolax suppository 10 mg was not given in April 2025. May 2025 a dulcolax suppository was given on 5/5, 5/10, 5/19 and 5/27. Senna-S tablet 8.6-50 mg give 2 tablets by mouth every 24 hours as needed up to twice daily was not administered for April or May 2025. During an observation 5/28/25 at 9:39 a.m., R2 was transferred from her Broda (positioning) chair to her bed with use of lift and nursing assistant (NA)-A and NA-E. R2's incontinence pad was wet with no BM. Staff changed the pad, performed perineal care, placed a new pad and positioned R2 in the bed. R2 was non verbal. NA-A and NA-E indicated R2 has had issues with having BM's and can not verbalize pain but you can tell by her facial expressions and change in behavior when she is in pain and they report that to the nurse. On interview 5/28/25 at 1:13 p.m., registered nurse (RN)-C, hospice nurse, stated she was not aware R2 had not a BM for 5-6 days prior to R2's ER visit. RN-C stated R2 should have a BM every other day and recently wrote an order for a duclolax suppository order for every other day.	F 684	3. Audit every TMA to complete one eye drop administration a week, weekly x 4 then monthly x 3. Results will be brought to QAPI for the recommendation of continuation of audit. 4. Review 2 residents that receive anticoagulants and complete a skin assessment on the resident. Audit to be completed weekly x 4 and monthly x 3. Results will be brought to QAPI for the recommendation of continuation of audit. 5. Audit each glucometers control sheet to ensure each one was calibrated if needed. Audit weekly x 4 then monthly x 3. Results will be brought to QAPI for the recommendation of continuation of audit. 6. What is the date of completion? 7/9/25	

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RN-C would expect if that doesn't work hospice would be notified.

On interview 5/28/25 at 1:35 p.m., registered nurse (RN)-A stated each resident is different on the amount of days they can go without a BM. RN-A stated R2 should have a BM every other day and added R2 got "stopped up on us" and didn't have a BM for 3-4 days. RN-A stated night shift prints out a daily BM sheet for those who haven't had a BM in over a day. RN-A stated it is their (day shift) responsibility to check orders and give what is ordered for the resident.

On interview 5/28/25 at 1:46 p.m., NA-E stated NA's will document in the EMR if the resident had a BM on their shift.

On interview 5/29/25 at 11:45 a.m., the director of nursing (DON) stated after 2 days the resident should be offered milk of magnesia or whatever the orders state. For R2, the DON stated hospice added a suppository order after the ER visit to give on day 2 if no BM. The DON stated a BM report is printed out daily and residents who have not had a BM the day prior will end up on the list. Day staff are then to check orders and give whatever is ordered. The DON confirmed R2 was having difficulty with BM's and was sent to the ER as her abdomen was hard and staff could not remove any stool digitally (manually remove stool using a gloved finger). The DON reviewed the bowel movement report for R2 and confirmed R2 should not go as long as she did multiple days throughout the last 2 months without a BM and without further intervention or notification to the provider.

A Bowel and Bladder: Evaluation, Assessment,

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Toileting Programs policy dated 5/7/25 included:

Bowel Assessment
- During a 72-hour period, document bowel function in EMR.
- Establish the resident ' s own familiar terms and cues used for indication of a toileting need.
- The Bowel Evaluation UDA should be completed for residents who are incontinent or who have problems with elimination, such as constipation or a history of impaction or a change in condition that affects elimination patterns.

EYE DROP ADMINISTRATION

R7's face sheet received on 5/29/25, included diagnosis of dry eye syndrome.

R7's significant change MDS assessment dated 5/9/25, indicated R7 had moderately impaired cognition; clear speech, could understand and be understood. R7 was independent or required partial assistance or supervision with activities of daily living (ADLs).

R7's physician order dated 3/6/23, included Refresh Optive Mega-3 Solution. Instill 1 drop in both eyes three times a day for dry eye relief.

R7's care plan did not include a focus for dry eye syndrome.

During an observation on 5/28/25 at 11:19 a.m., trained medication aide (TMA)-A, instilled eye drops into R7's eyes. R7 was seated in her recliner. TMA-A asked R7 to tilt her head back. TMA-A placed the tip of a single use-plastic ampule up to R7's right eye, placing the tip between the upper and lower lids and squeezed the ampule. The tip of the ampule touched R7's

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eye lids. TMA-A did not pull the lower lid down to place the eye drop in that pocket, nor did she attempt to assist R7 opening her eyes to ensure the drops washed over the eyeball.

R133's face sheet received on 5/29/25, included a diagnosis of glaucoma (an eye condition that damages the optic nerve).

R133's admission MDS assessment dated 5/19/25, indicated intact cognition, moderate difficulty hearing, clear speech, could understand and be understood. R133 was independent or required supervision for ADLs.

R133's physician order dated 5/13/25, indicated pilocarpine HCL Ophthalmic Solution 2%. Instill 1 drop, right eye, three times a day for glaucoma.

During an observation on 5/28/25 at 11:32 a.m., TMA-A instilled eye drops into R133's right eye. R133 was seated in her wheelchair. TMA-A asked R133 to tilt her head back. TMA-A placed the tip of the multi-use bottle up to R133's right eye, placing the tip between the upper and lower lids and squeezed the bottle. The tip of the bottle touched R133's eye. TMA-A did not pull down the lower lid to place the eye drop in that pocket, nor did she attempt to assist R133 opening her eyes to ensure the drops washed over the eyeball. Further, the physician order indicated one drop in the right eye and TMA-A administered two drops.

During an interview on 5/28/25, at 11:34 a.m., while at the medication cart in the hallway, TMA was asked to verbalize the proper technique for instilling eye drops. TMA-A stated she placed the drop in the lower lid and tried not to touch tip of bottle to the eye. TMA-A stated she put the bottle

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F 684	Continued From page 32	F 684		

of eye drops in the middle of the eye and let it drop; "Sometimes it doesn't go because eye closes, so I have to give a second drop." TMA-A was informed of observations of not pulling down the lower lid and of touching the tip of the bottle to the eye. TMA-A stated where she used to work, a resident got a bruise on her eye from pulling down the lower lid, so she doesn't do that anymore. TMA-A didn't know if the facility had a policy on administering eye drops.

During an interview on 5/29/25 at 2:30 p.m., the director of nursing (DON) was asked to verbalize the proper way to instill eye drops. The DON described the process which included ensuring the eye lids were open and drops were placed in the lower lid. The DON was informed of findings during two observations. DON was not aware of any specific training on instilling eye drops; would expect TMA-A's and nurses to know how to do that properly.

The DON stated the facility medication administration policy did not include administration of eye drops and there were no separate policies for administration of eye drops.

SKIN ASSESSMENT

R4's face sheet received on 5/29/25, included diagnoses of heart failure, atrial fibrillation (irregular heart rate causing poor blood flow) and long-term use of anticoagulation (blood thinner).

R4's quarterly MDS assessment dated 4/29/25, indicated intact cognition, clear speech, could understand and be understood. R4's was independent or required supervision with ADLs.

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R4's physician orders dated 1/21/25, included Apixaban (blood thinner) oral tablet 2.5 mg (milligrams), give 2.5 mg by mouth two times a day for atrial fibrillation. A common side effect of a blood thinner is increased bleeding and bruising. Orders did not include monitoring of current bruises.

R4's care plan dated 1/27/25, indicated R4 was on anticoagulant therapy related to atrial fibrillation. The nurse was to report observations of various symptoms or changes, including bruising. In addition, the care plan with revision date of 4/23/25, indicated R4 had potential impairment to skin integrity related to anticoagulation and anti-platelet treatment evidenced by easy bruising.

R4's progress note dated 3/8/25 at 21:19 p.m., indicated she returned from the hospital via family vehicle.

Electronic documents titled Skin Observation - V 3, were reviewed which indicated weekly skin assessments (minus two weeks) since R4's return from the hospital on 3/8/25, and her initial admission skin check. Assessments were as follows:
--1/21/25 - admission skin check indicated no skin conditions.
--3/8/25 and 3/9/25, were identical and indicated "fading bruise to back of left hand." No measurements or characteristics were documented. Nothing documented regarding left forearm bruise.
--3/13/25 - no documentation of bruising
--3/20/25 - no documentation of bruising
--3/27/25 - no documentation of bruising
--4/3/25 - no documentation of bruising

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F 684	Continued From page 34 --4/10/25 - no documentation of bruising --4/17/25 - no documentation of bruising --4/24/25 - no documentation of bruising --Missed a week --5/8/25 - no documentation of bruising --Missed a week --5/22/25 - "left hand/arm area still bruised because of old IV" (intravenous infusion). No documentation of measurements or characteristics. --5/28/25 - no documentation of bruising During an interview and observation on 5/27/25 at 3:06 p.m., with R4 and family member (FM)-A, both acknowledged the significant bruise covering the entire lower left forearm and a bruise on the posterior left hand. Both stated the arm bruise was from the hospital IV but weren't sure if the hand bruise occurred in the hospital too. R4 pointed out what appeared to be a reddish contusion to the mid-lateral aspect of her left lower leg. R4 stated she hit her leg on her walker. R4 stated staff were not monitoring it and did not know if staff were aware of it. R4 wasn't sure how long it had been there - but not long. During an interview on 5/28/25 at 1:15 p.m., RN-A stated nursing did not monitor or measure bruising on R4's left arm and left posterior hand. RN-A stated R4 got the bruises from IV's during a hospitalization in March 2025. RN-A stated when a resident had a bruise there was no expectation for nursing to monitor them, nor a nursing order entered into the electronic medical record (EMR) to prompt nurses to monitor them. R4 did not know if a provider had been informed of R4's arm and hand bruising, nor did she think it was unusual for R4 to have the bruises two months later. Regarding new contusion to R4's mid-lateral	F 684		

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F 684	Continued From page 35 aspect of R4's lower left leg, RN-A stated the staff just noticed it, and the nurse practitioner (NP) would look at it when she came to the facility on 5/29/25, to conduct rounds. RN-A stated the new contusion (bruise) had not been documented because she forgot. RN-A acknowledged the importance of identifying and monitoring bruising on a resident who was on an anticoagulant. Only after the new contusion was brought to RN-A's attention, was it documented on 5/28/25, at 2:10 p.m., as follows: left lower leg, 8 cm (centimeters) X 3-centimeter bruise on outside of leg. No characteristics documented, such as color, warmth, drainage, or how contusion occurred. During an interview on 5/29/25 at 10:39 a.m., the DON and administrator were informed of R4's bruises to arm and hand and the lack of monitoring and documentation of the bruises. The DON stated, "You expect us to monitor every bruise? We would have to have a picture map of their body." The DON and administrator were also informed of the contusion to R4's leg. The DON stated she was unaware of it until RN-A informed her of it and measured it yesterday (5/28/25). The DON stated staff did skin assessments every week and would document a bruise initially, but no on-going monitoring and documentation occurred after that. On 5/30/25, at 3:30 p.m., the DON emailed the measurements of the arm and hand bruises: --Posterior left hand: 9.5 cm x 6.5 cm. R4 informed the DON she accidentally keeps hitting it on her walker. --Left forearm bruise: 22 cm x 14 cm. The DON indicated that bruise was from an IV during hospitalization.	F 684		

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A policy on monitoring non-pressure wounds was requested and not received.

GLUCOMETER QUALITY CONTROL

R7's face sheet received on 5/29/25, included type 2 diabetes with hyperglycemia (high blood glucose).

R7's significant change MDS assessment dated 5/9/25, indicated R7 had moderately impaired cognition; clear speech, could understand and be understood. R7 was independent or required partial assistance or supervision with activities of daily living (ADLs)

R7's physician orders dated 4/7/25, included insulin Lantus SoloStar Solution Pen-injector 100 UNIT/ML at bedtime. Inject 17 unit subcutaneously one time a day related to type 2 diabetes with hyperglycemia. In addition, dated 7/27/25: Blood sugar checks: notify provider if glucometer reads too low or too high. (Parameters were not defined).

R7's care plan dated 1/27/21, indicated R7 had diabetes mellitus and would have no complications through review period. Care plan dated 3/8/25, indicated R7 had diabetic therapy and insulin resistance. R7's condition would be monitored based on clinic practice guidelines or clinical standards of practice relate to Lantus (insulin).

R7's finger-stick blood glucose measurements were obtained twice daily before meals at 5:00 a.m., and 5:00 p.m. For the month of May (5/1/25, through 5/27/25), R 7's blood glucose was obtained 54 times and indicated the

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F 684	Continued From page 37 following: < 100 mg/dl (milligram per deciliter) = 1 100 to 150 mg/dl = 16 151 to 200 mg/dl = 19 201 to 250 mg/dl = 7 251 to 300 mg/dl = 8 301 to 350 mg/dl = 2 **According to the Centers for Disease Control (CDC), for people with diabetes, recommend keeping blood sugar levels between 80 and 130 mg/dl before meals. During an interview on 5/27/25 at 2:32 p.m., R7 stated sometimes her blood sugar was high early in the morning, adding she was really concerned it was so high because early in the morning, it should be lower. During an interview on 5/29/25 at 7:30 a.m., RN-A stated each diabetic resident had their own glucometer and stated glucometer's were no longer calibrated, adding that wasn't done anymore. RN-A stated if there was a questionable finger-stick glucose, nurses would use another residents glucometer and check the blood sugar again. R7's brand of glucometer was Assure Platinum. RN-A was not aware of any unusual finger-stick glucose readings for R7. During an interview on 5/29/25 at 10:09 a.m., the DON stated the instructions for the glucometer's did not indicate they needed to be calibrated. During an interview on 5/29/25 at 11:45 a.m., the DON provided a binder with paper logs titled: "Assure Platinum Blood Glucose Monitoring System: Quality Control Record." The DON stated she contacted a night shift nurse and learned they did perform glucometer calibration	F 684		

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F 684	Continued From page 38 (also known as quality controls) once per month. The DON stated the night shift nurse was also responsible for restocking each residents glucometer container too (small plastic containers with lids kept in the medication cart) and which stored the residents glucometer, test strips, needles, and cotton balls. In the binder were seven paper logs dated 10/19/24, 11/5/24, 11/22/24, 12/23/24, 2/11/25, 3/11/25, 4/1/25, but none for May 2025. Review of the log sheets indicated the last quality control check for any resident was on 4/1/25. Since R7's blood sugar was checked twice daily and 4/1/25, was 58 days ago, 116 glucometer test strips would have been used, meaning one or two new containers of 50 test strips had to have been opened. There was no documentation of quality control checks being done. During an interview on 5/29/25 at 1:37 p.m., the DON was informed of the preceding findings and agreed that was accurate. The DON stated three or four residents had recently had unusually high blood sugars, but nothing had been done about it. The DON stated she thought the unusually high blood sugars were related to food, not glucometers. The DON stated they had not done any quality checks of the glucometers when they noticed resident blood sugars were unusually high. The DON stated their policy on calibration was whatever the manufacturer of the glucometer indicated. The manufacturer instructions indicated to recalibrate the glucometer when a battery is changed and/or with each new bottle of test strips or whenever there was suspicion the meter or test strips may not be functioning properly. The DON stated with unusually high finger stick glucose readings, she wouldn't think	F 684		

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F 684	Continued From page 39 to check the glucometers. The DON stated she did not know why quality controls had not been performed in April or May. Inside the binder indicated the following undated instructions for when to perform a control solution test: 1. Before testing with the Assure Platinum System for the first time. 2. When you open a new bottle of test strips. 3. Whenever you suspect the meter or test strips may not be functioning properly. 4. If test results appear to be abnormally high or low or are not consistent with clinical symptoms. 5. The test strip bottle had been left open, or had been exposed to light, temperatures below 39 degrees Fahrenheit or above 80 degrees F, or humidity over 80%. 6. To check your technique. 7. When the Assure Platinum Meter had been dropped or stored below 32 degrees F or above 122 degrees F. 8. Each time the batteries are changed. Facility Blood Glucose Monitoring, Disinfecting and Cleaning policy dated 9/25/24, indicated one of the purposes of the policy was to perform quality control testing on the testing instrument. All locations would have a current Clinical Laboratory Improvement Amendments (CLIA) waiver. Quality control tests to ensure calibration and techniques will be performed and documented on each glucose-testing instrument once a day or as directed by the manufacturer. These quality control tests will be conducted by running samples with known glucose readings to see if the readings obtained during the quality control tests are the same as the known readings. These identified "control" or "standard"	F 684		

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F 684	Continued From page 40 samples are obtained from the manufacturer of the instrument. Each nurse who conducts glucose testing will have on file documentation that they have had annual in-service training on the technique and precautions required to perform the test. General procedures included: Perform quality control tests once a day or as directed by the manufacturer. Document results in appropriate log. Follow the manufacturer ' s instructions for the specific device for performing the test, doing instrument calibration and the type of preventive maintenance and frequency. Log this preventive maintenance regarding each glucose meter. Glucose testing, if required by state regulations, should be included in the QAPI Program through correlation studies (having the laboratory draw a sample at the same time a finger stick is done and comparing the results). If the results are not consistently accurate, enrollment in proficiency testing may be required. If the blood sugars have been stable, other alternate sites that may be used include the thumb, palm, forearm, and thigh. Note that it is often difficult to get blood from these areas and the lancing device may need to be adjusted.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688		7/9/25

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F 688	Continued From page 41 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain and/or prevent loss of range of motion (ROM) for 1 of 2 residents (R7) reviewed for limited range of motion. Findings include: R7's face sheet received on 5/29/25, included diagnoses of chronic kidney disease, diabetes, dementia, Alzheimer's disease, muscle weakness and difficulty walking. R7's significant change Minimum Data Set (MDS) assessment dated 5/9/25, indicated R7 had moderately impaired cognition; clear speech, could understand and be understood. R7 was independent or required partial assistance or supervision with activities of daily living (ADLs). R7 used a walker or wheelchair for mobility. R7 was able to walk 10 feet with supervision, but 50-100 feet was not attempted. R7's current physician orders printed on 5/29/25, did not include an order for physical therapy evaluation and treat. R7's care plan with revision date of 1/13/25, indicated R7 had a need for restorative	F 688	F688 Increase/Prevent Decrease in ROM/Mobility 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R7□s care plan was updated; she was offered restorative therapy and upon her approval we requested therapy to reevaluate her to review her current restorative needs. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents with ADL deficits have the potential to be affected. Offered each of these residents who have had a decline in their deficits, the option to receive restorative therapy. We then asked therapy to evaluate those who wanted restorative therapy to review their current restorative needs. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? All CNAs were educated on restorative therapy utilizing several of our restorative policies: Restorative documentation,	

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F 688	Continued From page 42 intervention related to activity intolerance, limited ROM, limited mobility. Goal was for R7 to maintain current level of function. Interventions included nursing rehabilitation: active range of motion per OT (occupational) and PT (physical therapy) notes. In addition, the care plan dated 3/8/25, indicated R7 had osteoarthritis and would be/remain free of complications related to arthritis pain including pain, swelling and difficult mobility. R7's Kardex printed on 5/29/25, indicated staff should encourage routine physical activities and encourage walking on a daily basis. Restorative nursing recommendations by physical therapy assistant (PTA)-C dated 11/5/24, and titled: RNP (restorative nursing program) and Walking Program, indicated the following recommendations: -- Upper extremity 1 # dowel 2 X 10 all planes. -- LE (left extremity) AROM (assisted range of motion) in seated, all motions with 2 # GTB (unknown abbreviation), 2 X 15 -- NuStep (recumbent exercise machine) L (level) 2-3 X 10 minutes -- Walk using FWW (front wheel walker), CGA (contact guard assist), gait belt and WC (wheelchair) to following averaging 50 feet per bout. -- Complete 5 X / week. During an interview on 5/27/25 at 2:36 p.m., R7 stated they used to walk me in the hallway, but not anymore, I don't know why. would like to walk in the hallway to stay limber. During an observation on 5/29/25 at 8:47 a.m., R7 was sitting in her recliner. R7 spent most of the day observed in recliner unless she was at	F 688	implementing and screening for restorative and Identifying ADL decline for restorative. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Audit two residents a week on restorative therapy to ensure they□ve received these services. Audit weekly x 4 then monthly x 3. Results will be brought to QAPI for the recommendation of continuation of audit. 5. What is the date of completion? 7/9/25	

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F 688	Continued From page 43 meals. During an interview on 5/29/25 at 8:49 a.m., nursing assistant (NA)-D stated the facility used to have a restorative aide, then due to low census the position was eliminated. NA-D stated NA's were never instructed they were supposed to start doing restorative nursing cares with residents. NA-D stated R7 usually stayed in her room except for church and some music programs. During an interview on 5/29/25 at 9:06 a.m., NA-B stated R7 was on a restorative nursing program and that NA-B did ROM exercises to R7's arms. When asked how NA-B knew what kinds of restorative exercises to do with R7, NA-B stated it was listed in POC (Point of Care) in the EMR. (POC was where NA's looked for individualized tasks/care for residents and documented when completed). During review of R7's POC on 5/29/25, at 9:08 a.m., did not list any restorative nursing functions, including ROM or ambulation. During an interview on 5/29/25 at 10:09 a.m., with the director of nursing (DON) and administrator, the administrator stated the facility used to have a restorative aide - nursing assistant (NA)-C, who went on a leave of absence and didn't return. Her employment ended on 1/14/25. The administrator stated now restorative nursing was done by all NA's, and therapy staff helped, however the DON admitted they had not communicated that to NA's nor trained them how to perform the restorative nursing recommendations from PT. Both the DON and administrator indicated their restorative nursing program stopped when NA-C left.	F 688		

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	245593	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

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F 688	Continued From page 44 Facility Restorative, Nursing Care Implementation and Screening policy dated 11/27/24, indicated the purpose was to provide appropriate restorative nursing care to each resident, to identify residents appropriate for restorative nursing program. Each resident would receive restorative nursing care to the extent possible based on individual needs. Restorative aide would be trained in rehabilitation/restorative techniques per job description. The goal of restorative nursing care was to attain and maintain the maximum possible independence and/or prevent rapid declines though their interventions for each resident. Residents were provided appropriate treatment and services to attain/maintain functional abilities of ADLs. The restorative nurse had the overall responsibility and accountability for the restorative program. In the event the location did not have a designated restorative nurse, the responsible and accountability remained with the DON or designee.	F 688		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		7/9/25

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F 880	Continued From page 45 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 46 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control practices were followed for 1 of 1 resident (R12) reviewed for infection control when the tip of urinary drainage tubing was observed laying on the bathroom floor. In addition, the facility failed to clean and maintain reusable urinary drainage bags to minimize the potential for infection for R12. Findings include: R12 face sheet provided on 5/29/25, included diagnoses of urinary retention, hydronephrosis (excess fluid in kidney), flaccid neuropathic bladder (underactive bladder). R12's significant change Minimum Data Set (MDS) assessment dated 5/9/25, indicated R12 had intact cognition, clear speech, could understand and be understood. R12 had an indwelling urinary drainage catheter and required supervision with most ADLs, including walking. R12's physician orders included: Insert 16 F	F 880	F880 Infection Prevention and Control 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R12□s catheter cover was placed correctly back on the tip of the catheter. His reusable urinary drainage bag was also cleaned adequately. 2.How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents with catheters have the potential to be affected. We offered every resident with a catheter the option to stop changing their catheter bag every day and night and switch to either just a night bag or a day bag to help prevent infection. We also made sure their current catheter bag was adequately clean and had the cover in place by following our policy and procedure and educating CNAs and Nurses on this policy. 3.What measures will be put into place, or what systemic changes will be made, to	

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F 880	Continued From page 47 (French) catheter with 10 ml (milliliter) balloon every 30 days for urinary retention. (There was no order for a leg bag. Facility policy indicated: leg bags may be used with a physician's order). R12's care plan dated 4/28/25, indicated enhanced barrier precautions related to indwelling catheter. The care plan did not identify leg bag or cleaning the overnight urinary drainage bag using vinegar/tap water solution, and the technique to prevent risk of infection. Care plan dated 4/13/25, indicated R12 had an infection of the urinary system and would be free from complications. R12's Kardex printed on 5/29/25, indicated R12 had an indwelling foley catheter. The Kardex did not identify a leg bag or cleaning the overnight urinary drainage bag using vinegar/tap water solution, and the technique to prevent risk of infection. During an observation on 5/27/25 at 11:43 a.m., in R12's bathroom, a gray plastic basin was sitting on the floor next to the toilet/under the sink. In the basin was a large jug of vinegar, a urinal without a cover, and urinary drainage bag. The distal end of the tubing of the urinary drainage bag was setting on the floor, no cap on the end. Two clear plastic graduates were sitting on the handicapped bar next to the sink/toilet. One was dated 1/18/25, and had a catheter tip syringe in it and the other graduate was not dated. During an observation and interview on 5/27/25 at 11:48 a.m., nursing assistant (NA)-A who was preparing to empty R12's leg bag was asked to look at the urinary drainage bag in the bathroom. NA-A stated the tubing shouldn't be on the floor because it could cause R12 a bladder infection.	F 880	ensure that the deficient practice does not recur? All CNAs and nurses were educated on catheters via our Catheters: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen policy to ensure the covers of catheters are always placed back on the tip of the catheter as well as how to properly clean the reusable bags every time it is needed. 4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Audit one catheter a week to ensure the cover is on the tip of the catheter, that it was properly cleaned if needed and that it was stored off the ground correctly. Audit weekly x 4 then monthly x 3. Results will be brought to QAPI for the recommendation of continuation of audit. 5.What is the date of completion? 7/9/25	

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F 880	Continued From page 48 NA-A stated the urinary drainage bag was R12's overnight urinary drainage bag. NA-A stated when staff removed it in the morning to attach R12's leg bag, they put half tap water and half vinegar in a graduate, then using the cath-tip syringe put the solution into the distal end of the tubing which then flowed into the bag. During an observation on 5/27/25 at 1:24 p.m., observed the urinary drainage bag tubing still on the bathroom floor. During an observation and interview on 5/27/25 at 1:54 p.m., together with the director of nursing (DON), went to R12's bathroom. The tubing was still on the floor. The DON stated there should be a cap on the end of the tubing; that staff should keep the cap available to reuse it. The DON stated the jug of vinegar, and the urinal shouldn't be in the basin - just the drainage bag with tubing coiled up in it. The DON set the jug of vinegar on the floor and threw away the urinary drainage bag as well as the urinal. The DON stated the urinary drainage bag was changed weekly along with the graduate and syringe. The DON acknowledged according to the date; the graduate had been in use longer than a week. The DON also acknowledged the potential for R12 to obtain a urinary tract infection (UTI) had the contaminated tubing been reattached to his urinary catheter after having laid on the floor. During an observation and interview on 5/28/25 at 9:20 a.m., observed NA-A empty the urine from R12's overnight urinary drainage bag into the toilet. Next, using water from the faucet, NA-A put water in the graduate, then added an approximately equal amount of vinegar for a total of about 200 ml (milliliters). Using a cath tip	F 880		

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F 880	Continued From page 49 syringe, NA-A drew up the solution and injected it into the distal tip of tubing of the urinary drainage bag. The solution went into bag. NA-A then capped the distal tip and set the urinary drainage bag in the basin and coiled the tubing on top of the bag. NA-A stated the solution was kept in bag until the bag was used again at night. During an observation and interview on 5/28/25 at 3:30 p.m., together with registered nurse (RN)-B who was also the infection preventionist, went to R12's bathroom. After observing the urinary drainage bag in the basin on the floor, the jug of vinegar, graduate and syringe, RN-B stated she was unaware of the practice of NA's using tap water and vinegar to flush the overnight urinary drainage bags. RN-B stated the organization was looking at ways to reduce urinary tract infections by maintaining a closed catheter system. During an observation on 5/29/25 at 8:44 a.m., observed the overnight urinary drainage bag in the basin on the floor in R12's bathroom. The distal tip of tubing was uncapped and on top of bag and the cap was sitting on another part of the bag. During an interview on 5/29/25 at 10:31 a.m., with the DON and administrator, informed them of findings, including the observation of the uncapped tip of the urinary drainage bag from that morning. The DON stated one of their performance improvement projects was on UTI's. Was aware R12 had a recent UTI. Facility Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen policy dated 4/6/25, indicated: --All closed collection systems that become	F 880		

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F 880	Continued From page 50 contaminated by inappropriate technique, leaks or other means are immediately replaced. --Leg bags may be used with a physician's order. --Catheter tubing should never be allowed to touch the floor. --To clean the bag not in use: Be sure to close the bottom port of the bag that was emptied and not in use. Rinse the bag with warm (not hot) soapy water or bacteriostatic solution such as one-part white vinegar and three parts water solution or an appropriate commercial solution. Pour solution into the bag. Swish the solution around being sure to get the corners of the bag. Hint: A 60 ml syringe may be used to get solution into bag, be sure to clean the tip of the syringe with alcohol wipe before use and store in clean dry place. Soak the bag for 30 minutes. Open the bottom drainage port and drain the solution from the bag. Rinse the bag with warm water and hang to dry in the residents restroom covered with a clean towel. g. Cover/cap the tubing once the bag is dry.	F 880		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide the required Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) to 2 of 3 residents (R182, R184) whose Medicare Part A coverage ended and remained in the facility. Findings include: R182's face sheet printed 5/28/25, indicated diagnoses of cerebral vascular accident (stroke) and impaired mobility. R182's significant change Minimum Data Set (MDS) assessment dated 2/3/25, indicated intact cognition, no rejection of care, upper and lower extremity impairment on one side, and use of a wheelchair.

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F 582	Continued From Page 1

R182's care plan dated 1/10/25, indicated activity of daily living (ADL) self-care performance deficit related to stroke history and impaired mobility. Care plan further indicated R182 could walk with staff assistance and required partial/moderate assistance with dressing and grooming.

On 2/26/25, R182 signed form CMS 10123 titled Notice of Medicare Non-Coverage (NOMNC) indicated coverage of skilled nursing services would end on 2/28/25.

Review of R182's medical record indicated a SNF ABN form had not been provided to R182 to inform him of the estimated cost per day, or an explanation of the extended care services or items to be furnished, reduced, or terminate if he stayed in the facility.

R184's face sheet printed 5/28/25, indicated diagnoses of dementia, heart failure, chronic pain, and fracture of the spine.

R184's significant change MDS assessment dated 5/2/25, indicated severely impaired cognition, use of wheelchair, and substantial/maximal assistance with dressing, personal hygiene, and toilet use.

R184's care plan dated 1/16/25, indicated ADL self-care performance deficit related to weakness and history of falls. Care plan further stated resident was dependent with grooming, hygiene, and transfers with use of total lift.

On 3/3/25, R184 signed form CMS 10123 titled Notice of Medicare Non-Coverage (NOMNC) indicated coverage of skilled nursing services would end on 3/5/25.

Review of R184's medical record indicated a SNF ABN form had not been provided to R184 to inform her of the estimated cost per day, or an explanation of the extended care services or items to be furnished, reduced, or terminated if she stayed in the facility.

During interview on 5/28/25 at 10:40 a.m., social services director (SSD)-A stated no SNF ABN was given to R182 or R184. SSD-A further stated she normally issued the SNF ABN, but had been out of the facility for an extended time and whoever was covering was not giving notices correctly. SSD-A further stated she was unaware if a specific person was assigned to the task while she was out of office.

During interview on 5/28/25 at 1:22 p.m., administrator stated the business office and team tried to cover the issuing of the SNF ABN while SSD-A was out of office, but it was mostly the administrator's responsibility. Administrator further stated she knew the NOMNC needed to be issued but was unaware the SNF ABN also needed to be issued for residents staying in the facility. Administrator stated they needed to develop a process for coverage of duties when SSD-A is out of office.

Facility Medicare and Medicaid Benefits-Rehab/Skilled policy dated 12/12/24, indicated residents would be informed before, or at the time of admission, and periodically during the resident's stay, of available services

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F 582	Continued From Page 2 and charges, including any charges for services not covered under Medicare/Medicaid or by the location's daily rate.
F 628	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;

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F 628	Continued From Page 3

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245593	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 5/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	**1000 SOUTH SECOND STREET ST JAMES, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.

§483.21(c)(2) Discharge Summary
When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:
(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure the resident and/or legal representatives had been informed of bed hold rights and ensure a written notice of transfer was provided for 1 of 1 resident (R26) reviewed for hospitalizations.

Findings include:

R26's significant change Minimum Data Set (MDS) assessment dated 3/4/25, identified R26 had intact cognition and diagnoses including osteomyelitis (infection of the bone), urinary tract infection and sepsis (blood infection).

A Notice of Voluntary Resident/Patient Transfer or Discharge form indicated R26 was transferred to the emergency department for abnormal urine on 2/17/25. The Notice of Voluntary Resident/Patient Transfer was provided to the resident on 3/11/25. R26's electronic medical record (EMR) lacked evidence a Notice of Bed-Hold was given.

R26's EMR included a progress note that R26 was sent to the hospital on 2/17/25 at 2:20 p.m., for abnormal urinalysis. A progress note on 2/25/25 at 1:26 p.m., indicated R26 returned from the hospital today.

A Notice of Voluntary Resident/Patient Transfer or Discharge form with date of notice provided 4/7/25, included R26 was transferred to emergency department related to osteomyelitis. Date of transfer was listed as 4/5/25.

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R26's progress notes dated 4/5/25 at 2:26 p.m. indicated R26 was taken to the emergency room (ER). A progress note dated 4/11/25, included R26 returned to the facility today. A Notice of Bed-Hold form dated 4/7/25, indicated a verbal bed hold was given by the resident on 4/5/25.

On interview 5/27/25 at 4:21 p.m., R26 stated she has been to the hospital 2 or 3 times since her initial admission due to infections. R26 stated does not remember getting any papers regarding her transfer or bed hold prior to her transfer.

On interview 5/28/25 at 1:48 p.m., registered nurse (RN)-A stated the facility sends a notice of transfer with the resident, and necessary records are sent with the resident to the emergency department. RN-A stated they attempt to get the Notice of Bed-Hold form signed and keep one copy and send the other to the hospital with the resident. If the resident is not coherent or able to sign, they contact the power of attorney for verbal permission for the bed hold.

On interview 5/28/25 at 4:09 p.m., licensed practical nurse (LPN)-A indicated the Notice of Bed-Hold form is delegated to the nursing assistant to get signed and she takes care of the getting the notice of transfer to the resident prior to discharge.

On interview 5/28/25 at 1:53 p.m., R26 stated she doesn't ever remember seeing a bed hold notice or signing one or receiving a notice of transfer form. R26 stated she doesn't know what a bed hold is. R26's family member was present and stated he was not aware of what a bed hold was either.

On interview 5/28/25 at 2:16 p.m., social services director (SSD)-A stated she generally gives the Notice of Transfer to the resident and stated for R26 confirmed the one wasn't given until R26 returned from the hospital. SSD-A confirmed a Notice of Bed-Hold form was missed for the hospitalization on 2/17/25.

On interview 5/29/25 at 11:29 a.m., the director of nursing (DON) stated the Notice of Bed-Hold form and Transfer Agreement should be completed when possible before the resident is transferred to the hospital. The DON added if resident is not able to sign the Bed Hold, the family should be notified and verbal permission received if the bed is to be held.

A Discharge and Transfer policy dated 3/28/25, included:
Before a location transfers or discharges a resident, the location must:
- Notify the resident and the resident ' s representative of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. The Notification of Transfer or Discharge or other state-required form, will serve as the written notice to be given to the resident and/or resident ' s representative.

Note: When a resident is temporarily transferred on an emergency basis to an acute care center, a notice of transfer must be provided to the resident and resident representative as soon as practicable before the transfer. Copies of notices for emergency transfers must also still be sent to the ombudsman, but they

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may be sent when practicable, such as in a list of residents on a monthly basis.

A Bed Hold policy dated 12/19/24 included:
At the Time of Transfer:
- The social worker or designated individual will provide the Notice of Bed-Hold Policy to the resident and/or resident representative, which specifies the duration of the bed-hold policy under the state plan and the facility policy regarding bed-holds.
- The social worker or designated individual will review the Notice of Bed-Hold Policy and explain that future admission is based on bed availability and the criteria listed in the Notice of Bed-Hold Policy.

In Case of Emergency Transfer:
- The resident's copy of the Notice of Bed-Hold Policy is sent with the other papers accompanying the resident to the hospital. The family member or resident representative, if any, is provided with the Notice of Bed-Hold Policy within 24 hours of the transfer.
- The Notice of Bed-Hold Policy should be mailed if family or the resident representative does not come to the facility to receive a copy.
- The charge nurse is responsible for completion of notification procedures if the transfer occurs at a time the social worker is not at the location.
- The social worker or designated individual will contact the resident/resident representative to inquire regarding their decision for holding a bed.
- In cases where the facility was unable to notify the resident representative, the social worker or designated individual will document multiple attempts to reach the resident ' s representative.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/28/2025. At the time of this survey, Good Samaritan Society St. James was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/02/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Good Samaritan Society St. James The facility has a capacity of 42 beds and had a census of 28 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		

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K 321	Continued From page 2	K 321		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 19.3.6.3.5. These deficient findings could have a	K 321	1. All resident rooms that are being used for storage had closures installed. 2. All storage areas were inspected for proper closures. 3. All needed staff will be trained in safety	7/9/25

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K 321	Continued From page 3 widespread impact on the residents within the facility. Findings include: 1. On 05/28/2025 at 10:57 AM, it was revealed by observation that vacant resident room 201 was being used to store combustible items and did not have a self-closing device on the door. 2. On 05/28/2025 at 11:42 AM, it was revealed by observation that vacant resident rooms were being used to store combustible items and did not have a self-closing device on the doors in the Post Acute wing. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 321	instructions for hazardous area requirements. 4. Audits will be completed on storage room doors by the maintenance manager or designee weekly x 4, monthly x2 and quarterly x2. Audits will be reviewed by QAPI. 5. Substantial completion will be obtained by 7/9/25.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install and and inspect corridor smoke dececctors per NFPA 101 (2012 edition), Life Safety Code Section 9.6.1.3 or NFPA 99 (2012 edition), Health Care Facilities Code, section 15.7.1.2, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code Section 17.7.4.1. This deficient finding could have a widespread impact on the residents within the	K 347	1. The smoke detector that was installed too close to the air duct was moved by a third party vendor by 7/2/25. 2. All resident rooms, common areas, storage areas and employee areas were checked to make sure all smoke detectors are spaced in accordance with NFPA requirements by 7/2/25. 3. All maintenance staff will be trained on	7/9/25

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K 347	Continued From page 4 facility. Findings include: On 05/28/25 at 11:25 AM, it was revealed by observation that the corridor smoke detector located in Section 2 near the Nurses Station was installed within 1 foot of an air duct. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 347	the NFPA requirements for smoke detector placement. 4. Audits will be completed on the smoke detectors by the maintenance manager or designee weekly x 4, monthly x2 and quarterly x2. Audits will be reviewed by QAPI. 5. Substantial completion will be obtained by 7/9/25.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors	K 363		7/9/25

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K 363	Continued From page 5 meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 05/28/2025 at 10:57 AM, it was revealed by observation that the door to resident room 201 would not latch. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 363	1. The door to resident room 201 was adjusted so it now latches. 2. All corridor doors will be checked to ensure operation of the door meets NFPA requirements by 7/3/25. 3. All maintenance staff will be trained on the NFPA requirements of corridor doors by 7/9/25. 4. Audits will be completed on corridor doors by the maintenance manager or designee weekly x 4, monthly x2 and quarterly x2. Audits will be reviewed by QAPI. 5. Substantial completion will be obtained by 7/9/25	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with	K 511		7/9/25

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K 511	Continued From page 6 NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.1.2 and NFPA 70 (2011 edition), National Electric Code, section 408.20. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/28/2025, at 10:43 AM, it was revealed by observation that the electrical panels located in the Service Entry corridor were not secured. 2. On 05/28/2025, at 11:07 AM, it was revealed by observation that the electrical panel located in the Section 1 West corridor was not secured. 3. On 05/28/2025, at 11:11 AM, it was revealed by observation that the electrical panel located in the Section 1 North corridor was not secured. 4. On 05/28/2025, at 11:34 AM, it was revealed by observation that the electrical panel located in the Section 2 South corridor was not secured. 5. On 05/28/2025, at 12:03 PM, it was revealed	K 511	1. All unsecured electrical boxes have been secured by 7/3/25. 2. All electrical boxes will be checked to make sure they are secured meeting NFPA requirements by 7/3/25. 3. All maintenance staff will be trained on the NFPA requirements for electrical boxes by 7/9/25 4. Audits will be completed on electrical boxes by the maintenance manager or designee weekly x 4, monthly x2 and quarterly x2. Audits will be reviewed by QAPI. 5. Substantial completion will be obtained by 7/9/25.	

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K 511	Continued From page 7 by observation that the electrical panel located in the administrative corridor was not secured. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 511		
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/28/2025 at 9:38 AM, it was revealed by a review of available documentation that the fire safety plan that was provided at the time of the	K 711	1. The facility□s fire safety plan will be adjusted to include the transmission of alarms to the fire department. 2. All fire safety plans will be checked to meet NFPA requirements. 3. All needed staff will be trained in the changes to the fire safety plan. 4. Audits will be completed on fire safety plan by the maintenance manager or designee weekly x 4, monthly x2 and quarterly x2. Audits will be reviewed by QAPI.	7/9/25

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K 711	Continued From page 8 survey did not include transmission of alarms to fire department. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 711	5. Substantial completion will be obtained by 7/9/25.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 23, 2025

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

Re: State Nursing Home Licensing Orders
Event ID: 7RFF11

Dear Administrator:

The above facility was surveyed on May 27, 2025 through May 29, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00697	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/27/25-5/29/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H55935508C (MN00112387) with licensing orders issued at 0265 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		7/9/25

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the resident representative and the medical provider following a fall with potential injury for 1 of 1 resident (R132) reviewed for notification of change. Findings include: R132's face sheet printed on 6/10/25, included diagnoses of dementia with agitation, psychosis and anxiety, and delusional disorder. R132's significant change Minimum Data Set (MDS) assessment dated 1/23/25, indicated R132 had severe cognitive impairment, unclear speech, was sometimes understood and could sometimes understand. R132 had frequent behaviors such as pacing and rummaging. R132 required supervision, partial assistance or was dependent on staff for activities of daily living. R132 could walk independently. R132's physician orders dated 2/27/25, indicated hospice order for evaluation and treat. R132's nursing order dated 2/6/25, indicated have staff walk R132 at least twice a shift every 4 hours related to dementia. R132's care plan included focus areas of: risk for falls related to incontinence, psychoactive drug use and wandering dated 12/3/23; terminal	2 265	Corrected	

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2 265	Continued From page 4 prognosis due to dementia and on hospice care dated 1/19/24, and impaired cognition related to dementia, revised date 11/6/24. During a telephone interview on 5/22/25 at 2:52 p.m. family member (FM)-C stated R132 fell the evening of 3/5/25, and FM-C was not notified. R132 fell again the morning of 3/6/25, and FM-C was notified. The nurse who called to inform FM-C told her this had been R132's second fall in two days. That was how FM-C learned of the first fall on 3/5/25. FM-C stated R132 had been in a lot of pain in his left leg after the falls. R132 subsequently passed away on 3/9/25, four days after the first fall. During a telephone interview on 5/28/25 at 6:51 p.m., FM-C stated no one had asked her, with R132's increasing leg pain, if she would want R132 to have an x-ray to determine if there had been a fracture. FM-C added, "they said they contacted hospice and would monitor him because he couldn't walk and would give him morphine" (a narcotic pain medication). Progress note dated 3/5/25 at 2:03 a.m., indicated R132 was found on floor shortly after power went out (due to city power outage). Possibility of resident falling due to having no light. Tried assessing vitals and neuros (neurological status) while resident was on ground, but resident kept trying to get up. Resident was moved from floor to bed via Hoyer (mechanical lift) with help of nursing assistant (NA). Resident did wince when left leg was touched. Progress note dated 3/5/25 at 2:09 a.m., indicated the administrator and DON (director of nursing) notified through text message.	2 265		

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2 265	Continued From page 5 Information sheet filled out for certified nurse practitioner (CNP)-D. Resident's family will be notified during business hours. (There was no follow up documentation indicating FM-C was notified). Progress note dated 3/5/25 at 9:05 p.m., indicated hospice was called and updated on fall from late last night. Updated on use of morphine for pain/discomfort. Unable to bear weight on LLE (left lower extremity), required assist of two to transfer into bed. Hospice progress note dated 3/5/25 (no time noted), by hospice triage registered nurse (RN) indicated: Patient fell. Having some hip pain. Advised hospice recommends least invasive treatment and to defer to patients POA (power of attorney) for course of treatment. Progress note dated 3/6/25 at 9:10 a.m., indicated R132 was found on floor sitting beside bed, moaning of pain in left hip area; resident grabbed hip. Progress note dated 3/6/25 at 5:09 p.m., indicated hospice was notified to update them that resident is still not putting any weight on LLE. Resident says he's in pain, but that's the only information you can get out of resident. Hospice said to keep up with morphine PRN (as needed) and they will be sending out a nurse to come see resident. Hospice progress note dated 3/6/2025 (no time noted), indicated (RN)-D who was a hospice nurse, was at facility for a post-fall visit. Facility nurse reports R132 had a fall last night at 9:00 p.m., that was unwitnessed. After fall, according to [hospice] triage, it was reported R132 was	2 265		

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2 265	Continued From page 6 having trouble bearing weight and having right lower extremity pain and was given prn morphine. R132 was not transported to the hospital according to facility nurse. Facility nurse reports R132 was requiring a two-person transfer after fall. Facility nurse reports R132 had another fall this morning after breakfast that was a non-witnessed fall. R132 was helped back to bed, given morphine, which was effective and prn O2 (oxygen) was applied due to saturations in the 60's. R132 was observed resting in bed with O2 on via nasal cannula at 2 liters per minute. R132 was keeping the O2 on which was out of the ordinary. R132 was not responsive to voice or touch which was his baseline when sleeping. R132 continued to have full body involuntary movements where his whole body would twitch. R132 appeared very comfortable. Spoke to FM-C who reports she was not aware of the fall last night until just now; she would like to schedule morphine at this time to try to keep him comfortable and perhaps dissuade R132 from trying to get up again today. Progress note dated 3/6/25 11:51 a.m., indicated IDT (interdisciplinary team) met to review incident of R132 trying to ambulate in the dark and fell. Will get R132 a night light that has battery powered back up for if the lights go out. Progress note dated 3/6/25 at 9:01 p.m., indicated staff not able to carry out nursing order to walk R132 at least twice a shift due to recent fall as R132 not unable to bear weight on left leg. Progress note dated 3/7/25 dated 12:32 a.m., indicated staff not able to carry out nursing order to walk R132 at least twice a shift due to no weight bearing on left hip.	2 265		

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2 265	Continued From page 7 Progress note dated 3/8/25 at 8:20 p.m., indicated R132 had remained in bed throughout the shift. Knees were bent, opening slowly, and then quickly closed continuously. Has received scheduled and prn MS (morphine) and prn Ativan (anti-anxiety medication). Receiving O2 via a mask due to mouth breathing. Has not exited his bed. Progress note dated 3/9/25 at 5:00 a.m., indicated R132's condition was poor. In the dying process. MS (morphine) and lorazepam (anti-anxiety medication) given as ordered but has difficulty swallowing. Comfort measures done. Mouth care. Has been incontinent of urine several times. Turned and repositioned for comfort. Progress note dated 3/9/25 at 8:02 a.m., and identified as a late entry indicated spoke to FM-C about R132's condition and if they would want to come sit with him as his condition was deteriorating more quickly. Hospice progress note dated 3/9/25, (no time noted), family present at bedside. Facility reports pt has not eaten since fall on Tuesday (3/6/25) and has only tried to get out of bed once. Observed nonresponsive in bed with oxygen on. Mouth breathing. No periods of apnea (temporary cessation of breathing) noted. Respirations are somewhat agonal (last gasps). Discussed with family signs and symptoms of end of life. They appear to be coping well and prepared for this. Pt appears comfortable and not in distress. Discussed protocol with facility for when pt passes. Progress note dated 3/9/25 at 8:05 a.m., and identified as a late entry indicated hospice was	2 265		

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2 265	Continued From page 8 notified of residents failing state of health and will come to assess resident condition. Resident passed after hospice nurse left, and she was to be notified of his passing to call the funeral home and details. Progress note dated 3/9/25 at 13:51 p.m., indicated on-call nurse practitioner was updated on death and received order to release residents body. During an interview on 5/29/25 at 7:39 a.m., registered nurse (RN)-A stated R132 had pain after his falls and thought he had an x-ray. While looking for documentation in the EMR (electronic medical record) for an x-ray, RN-A found a fax communication dated 3/6/25 at 10:30 a.m., from the facility to certified nurse practitioner (CNP)-D which indicated R132 was found on the floor at 9:10 a.m. Left hip pain and moaning. Vital signs within normal limits. Skin assessment done. Oxygen applied. CNP-D informed the facility to follow up if problems weight bearing and increased pain. RN-A did not know if or how that order would have been shared with all nurses if they had not seen the fax. No order had been entered into the EMR to prompt nurses to monitor R132's weight bearing and pain, and to notify CNP-D. During an interview on 5/29/25 at 9:14 a.m., CNP-D reviewed the fax communication dated 3/6/25 at 10:30 a.m. CNP-D states she did not recall being informed R132 was having increased pain and problems with weight bearing as she had ordered staff to do. CNP-D stated had staff informed her R132 had not been bearing weight and had increased pain, she would have ordered an x-ray, then talked to the family to ask if they agreed. If they agreed, the x-ray was	2 265		

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2 265	Continued From page 9 ordered, if they did not want an x-ray, the order would be canceled. CNP-D stated it would have at least initiated a conversation. CNP-D acknowledge the fall, and potentially undetected fracture could have hastened his death, stated, "Yes, it could have contributed to it. R132 was very thin and had no cushion, so there was a high chance he had a fracture." During an interview on 5/29/25 at 9:53 a.m., the director of nursing (DON) and the administrator were asked about the following events: 1. Was 132's family notified of the fall on 3/5/25, at approximately 2:00 a.m.? Progress notes dated Monday 3/5/25, at 2:09 a.m., indicated, "residents family will be notified during business hours." There was no documentation in the EMR to indicate family was notified. The DON stated staff usually notified family no matter what time of day an event occurred. The administrator stated FM-C had been informed after the second fall. 2. Did the nursing staff follow CNP-D order to follow up with her if R132 had problems weight bearing and increased pain? The DON stated the staff would have notified hospice. The DON was asked if staff would call hospice even though the order came from CNP-D. The DON stated she found it hard to believe staff did not follow up with CNP-D and stated she would look for that documentation. The DON and administrator stated they were unaware R132 had been having increasing difficulty bearing weight and having increased pain. 3. FM-C was not given opportunity to decide if R132 should have an x-ray to determine if a fracture occurred after the falls. The DON stated FM-C had been given that opportunity. The DON was asked for that documentation.	2 265		

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2 265	Continued From page 10 The DON provided a document titled Nursing Home Scheduling, which was a form prepped by the facility to indicate names of residents who should be seen during a provider visit. This document was dated 3/6/25, and did not include R132. The DON acknowledged this would have been an opportunity to request CNP-D to see R132. The DON did not know why R132 had not been added to this schedule. An email received from the DON dated 5/30/25 at 2:56 p.m., indicated no documentation had been found indicating FM-C has been notified of R132's fall on 3/5/25. No documentation was found indicating CNP-D had been notified of R132's problems bearing weight and his increasing pain. Facility Notification Of Change policy dated 12/23/24, indicated a facility must immediately inform the resident, consult with the resident ' s physician and notify, consistent with his or her authority, the resident representative(s) when there is: 1) An accident involving the resident which results in injury and has the potential for requiring physician intervention. 2) A significant change in the resident ' s physical, mental or psychosocial status. 3) A need to alter treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and ensure policies and procedures related to timely notification of change were accurate, and then educate staff on the policies and procedures. The DON or designee could develop a monitoring system to audit periodically	2 265		

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2 265	Continued From page 11 and report the findings of those audits to the quality assurance performance improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to have an admission or quarterly care conference or invite and/or involve the resident and/or family representative to participate in their quarterly care conference for 3 of 3 residents (R26, R3, and R4) reviewed for care planning. Findings include: R26's Admission Record indicated admission to the facility on 1/9/25.	2 570	Corrected.	7/9/25

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GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

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2 570	Continued From page 12 R26's significant change Minimum Data Set (MDS) assessment dated 3/4/25, indicated R26 was cognitively intact, required substantial/maximal assistance with walking, toileting, and transfers. Diagnosis included osteomyelitis (bone infection), ileostomy status (surgical procedure that creates an opening in the abdomen for the ileum (the last part of the small intestine) to exit, allowing waste to be collected in an external pouch), sepsis (blood infection), and cystitis (inflammation of the bladder caused by urinary tract infection). R26's care plan dated 2/25/25 and last revised 5/20/25, included multiple care areas related to activities of daily living (ADLs), pain management and disease processes. R26's electronic medical record (EMR) did not include a care conference meeting note or that R26 was included in development and revisions of the plan of care. On interview 5/27/25 at 11:28 a.m., R26 stated she has not had any care conference meetings since being at the facility nor have they asked about her input for her care plan. R26 stated she is going home at the end of the week. On interview 5/28/25 at 1:53 P.M., R26 confirmed she has not had any care conference meetings since being at facility and was not involved in her care plan development. R26 stated she was surprised she hasn't had one as she was always involved with her mother's care conferences when she was a resident. On interview 5/28/25 at 2:16 p.m., social service director (SSD)-A confirmed R26 has not had a	2 570		

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2 570	Continued From page 13 care conference since she has been at the facility. SSD-A stated R26 should have had at least one care conference but added she had met with the resident and a family member but that did not include other team members. R3's Admission Record indicated admission to the facility on 7/2/24, with diagnoses including heart failure, dementia and major depressive disorder. R3's quarterly MDS dated 4/20/25, indicated moderate cognitive impairment, but usually understands and is understood. R26 had no behaviors, is on scheduled pain medications rating pain at 7 on scale of 1-10, and is on medications including opioid, antidepressant, anticonvulsant, antiplatelet and diuretic. R3 also has had one fall and requires partial to moderate assist with activities of daily living. On interview 5/27/25 at 1:38 p.m., R3, using interpreter service, stated they have never invited him to a care conference and he has not had any input into his plan of care at the facility since he has been here. Review of the electronic medical record (EMR) included a Care Conference on 4/16/25, which indicated 2 staff attended and R3 was invited but chose not to attend. The EMR lacked evidence of other care conferences. On interview 5/28/25 at 2:16 p.m., SSD-A stated R3 had a care conference initially but none since that time. SSD-A stated the facility had multiple people missing that generally attend care conferences so were not able to get the care conferences completed and were aware they were not in compliance.	2 570		

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2 570	Continued From page 14 On interview 5/29/25 at 11:29 a.m., the director of nursing (DON) stated care conferences should happen within the first 21 days the resident is at the facility and then quarterly after that. R4's face sheet received on 5/29/25, included diagnoses of heart failure, high blood pressure, and chronic kidney disease. R4's quarterly MDS assessment dated 4/29/25, indicated intact cognition, clear speech, could understand and be understood. R4 was independent or required supervision with ADLs. R4's care plan initiated 1/27/25, included multiple focus areas, goals and interventions. The care plan did not include care conferences. R4's care conference progress note dated 5/14/25 at 10:43 a.m., indicated staff and family member (FM)-A were present. Nursing reported on health and went over the medication. Increase weight was discussed. Family wants her treated only at the nursing home and not the hospital. Dietary reported on intake and weight. Code statue was reviewed, and remains a DNR (do not resuscitate). Family was given a copy of the care plan. Social worker reported on assessments and participation [in activities]. During an interview on 5/27/25 at 3:19 p.m., R4 and FM-A stated since R4's admission in January (1/21/25), R4 had only one care conference and that was a couple of weeks ago. FM-A stated she was aware the social worker had been out of work for a while. During an interview on 5/28/25 at 3:27 p.m., SSD-A stated she was responsible for arranging	2 570		

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2 570	Continued From page 15 and facilitating care conferences. SSD-A stated on 1/29/25, she had been getting ready to conduct multiple resident care conferences, including R4's when she became incapacitated and the care conferences that were scheduled that day where not done nor rescheduled. During an interview on 5/29/25 at 10:39 a.m., the DON and administrator were informed R4 had not had an initial care conference after admission in January due to SSD-A not being able to conduct them on 1/29/25. Informed R4's first and only care conference was on 5/14/25. The administrator thought the 1/29/25, care conferences had been rescheduled and would look for documentation. An email from the administrator dated 5/29/25 at 11:23 a.m., indicated unable to find documentation of an initial care conference, or talking with R4's family in the beginning of her stay. Facility Comprehensive Care Plan and Care Conferences policy dated 1/31/25, indicated the purpose was to provide an ongoing method of assessing, implementing, evaluating and updating the resident's care plan to help maintain the resident's highest practicable level of function. The social worker would establish the time and place to hold the care conference. Residents and their representative would be invited at least two weeks in advance of the care conference. If resident and/or representative were not invited to the care conference, an explanation would be included in the medical record. Residents and representatives would be informed of the right to request meetings, request revisions to the care plan and to be informed in advance of changes to the care plan. Residents had the right to see the	2 570		

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2 570	Continued From page 16 care plan and to sign the care plan after significant changes were made. If the resident requested to sign the care plan, print a signature page and the care plan from PCC (Point Click Care, electronic medical record). The social worker would function as the facilitator during the care conference, keeping the meeting on task and making certain that residents and/or their representatives had an opportunity to voice any concerns. The social worker would facilitate the discussion of the resident's care plan and summarize the changes since the last interdisciplinary team review. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and ensure policies and procedures related to conducting timely care conferences, included resident and/or family representative participation were accurate, and then educate staff on the policies and procedures. The DON or designee could develop a monitoring system to audit periodically and report the findings of those audits to the quality assurance performance improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as	2 875		7/9/25

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2 875	Continued From page 17 indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement bowel movement (BM) orders or notify the provider for 1 of 1 resident (R2) reviewed for constipation. In addition the facility failed to to administer eye drops according to professional standards of practice for 2 of 3 residents (R7, R133) reviewed for medication administration. In addition, the facility failed to comprehensively assess and monitor significant bruising and a contusion for 1 of 1 resident (R4) reviewed for non-pressure skin conditions. Further, the facility failed to perform quality controls on glucometers used to assess resident blood glucose for 1 of 3 residents (R7) reviewed for insulin. Findings include: Constipation R2's diagnosis report printed on 5/29/25, included dementia, and encounter for palliative (comfort) care. R2's quarterly Minimum Data Set (MDS) assessment dated 3/8/25, indicated severely impaired cognition, unclear speech, rarely understands or is understood and has severely impaired cognitive skills for daily decision making. R2 was dependent on staff for all activities of daily living (ADL's). R2 was receiving hospice services. R2's physician orders included Senna-S (laxative)	2 875	Corrected.	

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2 875	Continued From page 18 tablet 8.6-50 mg (milligrams) dated 7/17/24; Give 1 tablet by mouth one time a day; may give two tablets every 24 hours as needed for constipation. May give up to twice daily as needed. Contact provider/practitioner if there are 3 days without a significant BM. Additional physician orders dated 9/10/24, included dulcolax (laxative) suppository 10 mg every 6 hours as needed for constipation. Contact provider/practitioner if there are three days without a significant BM. An order from Hospice dated 5/11/25, included give dulcolax suppository every other day. R2's Care Area Assessment dated 12/9/24, did include urinary incontinence but did not include bowel issues. R2's care plan with revised date of 1/1/25, did not include care plan for constipation or bowel issues. On interview 5/27/25 at 2:00 p.m., family member (FM)-B stated R2 ended up in the emergency room (ER) because she hadn't "pooped in days". FM-B stated the ER didn't do anything because R2 is on hospice services. FM-B stated on her daily visit, she knew her mom was uncomfortable by her facial grimacing and staff told her she hadn't had a BM in multiple days. Record review identified R2 had no documented BM for: 4/1/25 to 4/5/25; 4/8/25 to 4/18/25; 4/19/25 to 4/29/25; 4/30/25 to 5/5/25, 5/8/25 to 5/13/25; 5/19/25 to 5/22/25; 5/23/25 to 6/1/25. A physician visit dated 5/2/25 at 10:30 a.m., included no acute concerns or complaints. Bowel status "good".	2 875		

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2 875	Continued From page 19 R2's medication administration record (MAR) indicated Senna-S tablet 8.6-50 mg was given 1 tablet by mouth one time a day April 1-30/2025 and May 1-31/25. A dulcolax suppository 10 mg was not given in April 2025. May 2025 a dulcolax suppository was given on 5/5, 5/10, 5/19 and 5/27. Senna-S tablet 8.6-50 mg give 2 tablets by mouth every 24 hours as needed up to twice daily was not administered for April or May 2025. During an observation 5/28/25 at 9:39 a.m., R2 was transferred from her Broda (positioning) chair to her bed with use of lift and nursing assistant (NA)-A and NA-E. R2's incontinence pad was wet with no BM. Staff changed the pad, performed perineal care, placed a new pad and positioned R2 in the bed. R2 was non verbal. NA-A and NA-E indicated R2 has had issues with having BM's and can not verbalize pain but you can tell by her facial expressions and change in behavior when she is in pain and they report that to the nurse. On interview 5/28/25 at 1:13 p.m., registered nurse (RN)-C, hospice nurse, stated she was not aware R2 had not a BM for 5-6 days prior to R2's ER visit. RN-C stated R2 should have a BM every other day and recently wrote an order for a duclolax suppository order for every other day. RN-C would expect if that doesn't work hospice would be notified. On interview 5/28/25 at 1:35 p.m., registered nurse (RN)-A stated each resident is different on the amount of days they can go without a BM. RN-A stated R2 should have a BM every other day and added R2 got "stopped up on us" and didn't have a BM for 3-4 days. RN-A stated night shift prints out a daily BM sheet for those who	2 875		

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2 875	Continued From page 20 haven't had a BM in over a day. RN-A stated it is their (day shift) responsibility to check orders and give what is ordered for the resident. On interview 5/28/25 at 1:46 p.m., NA-E stated NA's will document in the EMR if the resident had a BM on their shift. On interview 5/29/25 at 11:45 a.m., the director of nursing (DON) stated after 2 days the resident should be offered milk of magnesia or whatever the orders state. For R2, the DON stated hospice added a suppository order after the ER visit to give on day 2 if no BM. The DON stated a BM report is printed out daily and residents who have not had a BM the day prior will end up on the list. Day staff are then to check orders and give whatever is ordered. The DON confirmed R2 was having difficulty with BM's and was sent to the ER as her abdomen was hard and staff could not remove any stool digitally (manually remove stool using a gloved finger). The DON reviewed the bowel movement report for R2 and confirmed R2 should not go as long as she did multiple days throughout the last 2 months without a BM and without further intervention or notification to the provider. A Bowel and Bladder: Evaluation, Assessment, Toileting Programs policy dated 5/7/25 included: Bowel Assessment - During a 72-hour period, document bowel function in EMR. - Establish the resident ' s own familiar terms and cues used for indication of a toileting need. - The Bowel Evaluation UDA should be completed for residents who are incontinent or who have problems with elimination, such as constipation or a history of impaction or a change	2 875		

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2 875	Continued From page 21 in condition that affects elimination patterns. EYE DROP ADMINISTRATION R7's face sheet received on 5/29/25, included diagnosis of dry eye syndrome. R7's significant change MDS assessment dated 5/9/25, indicated R7 had moderately impaired cognition; clear speech, could understand and be understood. R7 was independent or required partial assistance or supervision with activities of daily living (ADLs). R7's physician order dated 3/6/23, included Refresh Optive Mega-3 Solution. Instill 1 drop in both eyes three times a day for dry eye relief. R7's care plan did not include a focus for dry eye syndrome. During an observation on 5/28/25 at 11:19 a.m., trained medication aide (TMA)-A, instilled eye drops into R7's eyes. R7 was seated in her recliner. TMA-A asked R7 to tilt her head back. TMA-A placed the tip of a single use-plastic ampule up to R7's right eye, placing the tip between the upper and lower lids and squeezed the ampule. The tip of the ampule touched R7's eye lids. TMA-A did not pull the lower lid down to place the eye drop in that pocket, nor did she attempt to assist R7 opening her eyes to ensure the drops washed over the eyeball. R133's face sheet received on 5/29/25, included a diagnosis of glaucoma (an eye condition that damages the optic nerve). R133's admission MDS assessment dated 5/19/25, indicated intact cognition, moderate	2 875		

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2 875	Continued From page 22 difficulty hearing, clear speech, could understand and be understood. R133 was independent or required supervision for ADLs. R133's physician order dated 5/13/25, indicated pilocarpine HCL Ophthalmic Solution 2%. Instill 1 drop, right eye, three times a day for glaucoma. During an observation on 5/28/25 at 11:32 a.m., TMA-A instilled eye drops into R133's right eye. R133 was seated in her wheelchair. TMA-A asked R133 to tilt her head back. TMA-A placed the tip of the multi-use bottle up to R133's right eye, placing the tip between the upper and lower lids and squeezed the bottle. The tip of the bottle touched R133's eye. TMA-A did not pull down the lower lid to place the eye drop in that pocket, nor did she attempt to assist R133 opening her eyes to ensure the drops washed over the eyeball. Further, the physician order indicated one drop in the right eye and TMA-A administered two drops. During an interview on 5/28/25, at 11:34 a.m., while at the medication cart in the hallway, TMA was asked to verbalize the proper technique for instilling eye drops. TMA-A stated she placed the drop in the lower lid and tried not to touch tip of bottle to the eye. TMA-A stated she put the bottle of eye drops in the middle of the eye and let it drop; "Sometimes it doesn't go because eye closes, so I have to give a second drop." TMA-A was informed of observations of not pulling down the lower lid and of touching the tip of the bottle to the eye. TMA-A stated where she used to work, a resident got a bruise on her eye from pulling down the lower lid, so she doesn't do that anymore. TMA-A didn't know if the facility had a policy on administering eye drops. During an interview on 5/29/25 at 2:30 p.m., the	2 875		

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2 875	Continued From page 23 director of nursing (DON) was asked to verbalize the proper way to instill eye drops. The DON described the process which included ensuring the eye lids were open and drops were placed in the lower lid. The DON was informed of findings during two observations. DON was not aware of any specific training on instilling eye drops; would expect TMA-A's and nurses to know how to do that properly. The DON stated the facility medication administration policy did not include administration of eye drops and there were no separate policies for administration of eye drops. SKIN ASSESSMENT R4's face sheet received on 5/29/25, included diagnoses of heart failure, atrial fibrillation (irregular heart rate causing poor blood flow) and long-term use of anticoagulation (blood thinner). R4's quarterly MDS assessment dated 4/29/25, indicated intact cognition, clear speech, could understand and be understood. R4's was independent or required supervision with ADLs. R4's physician orders dated 1/21/25, included Apixaban (blood thinner) oral tablet 2.5 mg (milligrams), give 2.5 mg by mouth two times a day for atrial fibrillation. A common side effect of a blood thinner is increased bleeding and bruising. Orders did not include monitoring of current bruises. R4's care plan dated 1/27/25, indicated R4 was on anticoagulant therapy related to atrial fibrillation. The nurse was to report observations of various symptoms or changes, including bruising. In addition, the care plan with revision	2 875		

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2 875	Continued From page 24 date of 4/23/25, indicated R4 had potential impairment to skin integrity related to anticoagulation and anti-platelet treatment evidenced by easy bruising. R4's progress note dated 3/8/25 at 21:19 p.m., indicated she returned from the hospital via family vehicle. Electronic documents titled Skin Observation - V 3, were reviewed which indicated weekly skin assessments (minus two weeks) since R4's return from the hospital on 3/8/25, and her initial admission skin check. Assessments were as follows: --1/21/25 - admission skin check indicated no skin conditions. --3/8/25 and 3/9/25, were identical and indicated "fading bruise to back of left hand." No measurements or characteristics were documented. Nothing documented regarding left forearm bruise. --3/13/25 - no documentation of bruising --3/20/25 - no documentation of bruising --3/27/25 - no documentation of bruising --4/3/25 - no documentation of bruising --4/10/25 - no documentation of bruising --4/17/25 - no documentation of bruising --4/24/25 - no documentation of bruising --Missed a week --5/8/25 - no documentation of bruising --Missed a week --5/22/25 - "left hand/arm area still bruised because of old IV" (intravenous infusion). No documentation of measurements or characteristics. --5/28/25 - no documentation of bruising During an interview and observation on 5/27/25 at 3:06 p.m., with R4 and family member (FM)-A,	2 875		

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2 875	Continued From page 25 both acknowledged the significant bruise covering the entire lower left forearm and a bruise on the posterior left hand. Both stated the arm bruise was from the hospital IV but weren't sure if the hand bruise occurred in the hospital too. R4 pointed out what appeared to be a reddish contusion to the mid-lateral aspect of her left lower leg. R4 stated she hit her leg on her walker. R4 stated staff were not monitoring it and did not know if staff were aware of it. R4 wasn't sure how long it had been there - but not long. During an interview on 5/28/25 at 1:15 p.m., RN-A stated nursing did not monitor or measure bruising on R4's left arm and left posterior hand. RN-A stated R4 got the bruises from IV's during a hospitalization in March 2025. RN-A stated when a resident had a bruise there was no expectation for nursing to monitor them, nor a nursing order entered into the electronic medical record (EMR) to prompt nurses to monitor them. R4 did not know if a provider had been informed of R4's arm and hand bruising, nor did she think it was unusual for R4 to have the bruises two months later. Regarding new contusion to R4's mid-lateral aspect of R4's lower left leg, RN-A stated the staff just noticed it, and the nurse practitioner (NP) would look at it when she came to the facility on 5/29/25, to conduct rounds. RN-A stated the new contusion (bruise) had not been documented because she forgot. RN-A acknowledged the importance of identifying and monitoring bruising on a resident who was on an anticoagulant. Only after the new contusion was brought to RN-A's attention, was it documented on 5/28/25, at 2:10 p.m., as follows: left lower leg, 8 cm (centimeters) X 3-centimeter bruise on outside of leg. No characteristics documented, such as color, warmth, drainage, or how contusion occurred.	2 875		

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2 875	Continued From page 26 During an interview on 5/29/25 at 10:39 a.m., the DON and administrator were informed of R4's bruises to arm and hand and the lack of monitoring and documentation of the bruises. The DON stated, "You expect us to monitor every bruise? We would have to have a picture map of their body." The DON and administrator were also informed of the contusion to R4's leg. The DON stated she was unaware of it until RN-A informed her of it and measured it yesterday (5/28/25). The DON stated staff did skin assessments every week and would document a bruise initially, but no on-going monitoring and documentation occurred after that. On 5/30/25, at 3:30 p.m., the DON emailed the measurements of the arm and hand bruises: --Posterior left hand: 9.5 cm x 6.5 cm. R4 informed the DON she accidentally keeps hitting it on her walker. --Left forearm bruise: 22 cm x 14 cm. The DON indicated that bruise was from an IV during hospitalization. A policy on monitoring non-pressure wounds was requested and not received. GLUCOMETER QUALITY CONTROL R7's face sheet received on 5/29/25, included type 2 diabetes with hyperglycemia (high blood glucose). R7's significant change MDS assessment dated 5/9/25, indicated R7 had moderately impaired cognition; clear speech, could understand and be understood. R7 was independent or required partial assistance or supervision with activities of daily living (ADLs)	2 875		

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2 875	Continued From page 27 R7's physician orders dated 4/7/25, included insulin Lantus SoloStar Solution Pen-injector 100 UNIT/ML at bedtime. Inject 17 unit subcutaneously one time a day related to type 2 diabetes with hyperglycemia. In addition, dated 7/27/25: Blood sugar checks: notify provider if glucometer reads too low or too high. (Parameters were not defined). R7's care plan dated 1/27/21, indicated R7 had diabetes mellitus and would have no complications through review period. Care plan dated 3/8/25, indicated R7 had diabetic therapy and insulin resistance. R7's condition would be monitored based on clinic practice guidelines or clinical standards of practice relate to Lantus (insulin). R7's finger-stick blood glucose measurements were obtained twice daily before meals at 5:00 a.m., and 5:00 p.m. For the month of May (5/1/25, through 5/27/25), R 7's blood glucose was obtained 54 times and indicated the following: < 100 mg/dl (milligram per deciliter) = 1 100 to 150 mg/dl = 16 151 to 200 mg/dl = 19 201 to 250 mg/dl = 7 251 to 300 mg/dl = 8 301 to 350 mg/dl = 2 **According to the Centers for Disease Control (CDC), for people with diabetes, recommend keeping blood sugar levels between 80 and 130 mg/dl before meals. During an interview on 5/27/25 at 2:32 p.m., R7 stated sometimes her blood sugar was high early in the morning, adding she was really concerned it was so high because early in the morning, it should be lower.	2 875		

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2 875	Continued From page 28 During an interview on 5/29/25 at 7:30 a.m., RN-A stated each diabetic resident had their own glucometer and stated glucometer's were no longer calibrated, adding that wasn't done anymore. RN-A stated if there was a questionable finger-stick glucose, nurses would use another residents glucometer and check the blood sugar again. R7's brand of glucometer was Assure Platinum. RN-A was not aware of any unusual finger-stick glucose readings for R7. During an interview on 5/29/25 at 10:09 a.m., the DON stated the instructions for the glucometer's did not indicate they needed to be calibrated. During an interview on 5/29/25 at 11:45 a.m., the DON provided a binder with paper logs titled: "Assure Platinum Blood Glucose Monitoring System: Quality Control Record." The DON stated she contacted a night shift nurse and learned they did perform glucometer calibration (also known as quality controls) once per month. The DON stated the night shift nurse was also responsible for restocking each residents glucometer container too (small plastic containers with lids kept in the medication cart) and which stored the residents glucometer, test strips, needles, and cotton balls. In the binder were seven paper logs dated 10/19/24, 11/5/24, 11/22/24, 12/23/24, 2/11/25, 3/11/25, 4/1/25, but none for May 2025. Review of the log sheets indicated the last quality control check for any resident was on 4/1/25. Since R7's blood sugar was checked twice daily and 4/1/25, was 58 days ago, 116 glucometer test strips would have been used, meaning one or two new containers of 50 test strips had to have been opened. There was no documentation of quality	2 875		

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2 875	Continued From page 29 control checks being done. During an interview on 5/29/25 at 1:37 p.m., the DON was informed of the preceding findings and agreed that was accurate. The DON stated three or four residents had recently had unusually high blood sugars, but nothing had been done about it. The DON stated she thought the unusually high blood sugars were related to food, not glucometers. The DON stated they had not done any quality checks of the glucometers when they noticed resident blood sugars were unusually high. The DON stated their policy on calibration was whatever the manufacturer of the glucometer indicated. The manufacturer instructions indicated to recalibrate the glucometer when a battery is changed and/or with each new bottle of test strips or whenever there was suspicion the meter or test strips may not be functioning properly. The DON stated with unusually high finger stick glucose readings, she wouldn't think to check the glucometers. The DON stated she did not know why quality controls had not been performed in April or May. Inside the binder indicated the following undated instructions for when to perform a control solution test: 1. Before testing with the Assure Platinum System for the first time. 2. When you open a new bottle of test strips. 3. Whenever you suspect the meter or test strips may not be functioning properly. 4. If test results appear to be abnormally high or low or are not consistent with clinical symptoms. 5. The test strip bottle had been left open, or had been exposed to light, temperatures below 39 degrees Fahrenheit or above 80 degrees F, or humidity over 80%. 6. To check your technique.	2 875		

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2 875	Continued From page 30 7. When the Assure Platinum Meter had been dropped or stored below 32 degrees F or above 122 degrees F. 8. Each time the batteries are changed. Facility Blood Glucose Monitoring, Disinfecting and Cleaning policy dated 9/25/24, indicated one of the purposes of the policy was to perform quality control testing on the testing instrument. All locations would have a current Clinical Laboratory Improvement Amendments (CLIA) waiver. Quality control tests to ensure calibration and techniques will be performed and documented on each glucose-testing instrument once a day or as directed by the manufacturer. These quality control tests will be conducted by running samples with known glucose readings to see if the readings obtained during the quality control tests are the same as the known readings. These identified "control" or "standard" samples are obtained from the manufacturer of the instrument. Each nurse who conducts glucose testing will have on file documentation that they have had annual in-service training on the technique and precautions required to perform the test. General procedures included: Perform quality control tests once a day or as directed by the manufacturer. Document results in appropriate log. Follow the manufacturer ' s instructions for the specific device for performing the test, doing instrument calibration and the type of preventive maintenance and frequency. Log this preventive maintenance regarding each glucose meter. Glucose testing, if required by state regulations, should be included in the QAPI Program through correlation studies (having the laboratory draw a sample at the same time a finger stick is done and comparing the results). If the results are not consistently accurate, enrollment in proficiency testing may be required.	2 875		

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2 875	Continued From page 31 If the blood sugars have been stable, other alternate sites that may be used include the thumb, palm, forearm, and thigh. Note that it is often difficult to get blood from these areas and the lancing device may need to be adjusted. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and ensure policies and procedures related to administration of eye drops, monitoring bruising, monitoring bowel movements, and performing quality control checks of glucometers were accurate, and then educate staff on the policies and procedures. The DON or designee could develop a monitoring system to audit periodically and report the findings of those audits to the quality assurance performance improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 875		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless	2 890		7/9/25

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2 890	Continued From page 32 the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain and/or prevent loss of range of motion (ROM) for 1 of 2 residents (R7) reviewed for limited range of motion. Findings include: R7's face sheet received on 5/29/25, included diagnoses of chronic kidney disease, diabetes, dementia, Alzheimer's disease, muscle weakness and difficulty walking. R7's significant change Minimum Data Set (MDS) assessment dated 5/9/25, indicated R7 had moderately impaired cognition; clear speech, could understand and be understood. R7 was independent or required partial assistance or supervision with activities of daily living (ADLs). R7 used a walker or wheelchair for mobility. R7 was able to walk 10 feet with supervision, but 50-100 feet was not attempted. R7's current physician orders printed on 5/29/25, did not include an order for physical therapy evaluation and treat. R7's care plan with revision date of 1/13/25, indicated R7 had a need for restorative intervention related to activity intolerance, limited ROM, limited mobility. Goal was for R7 to maintain current level of function. Interventions included nursing rehabilitation: active range of	2 890	Corrected.	

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2 890	Continued From page 33 motion per OT (occupational) and PT (physical therapy) notes. In addition, the care plan dated 3/8/25, indicated R7 had osteoarthritis and would be/remain free of complications related to arthritis pain including pain, swelling and difficult mobility. R7's Kardex printed on 5/29/25, indicated staff should encourage routine physical activities and encourage walking on a daily basis. Restorative nursing recommendations by physical therapy assistant (PTA)-C dated 11/5/24, and titled: RNP (restorative nursing program) and Walking Program, indicated the following recommendations: -- Upper extremity 1 # dowel 2 X 10 all planes. -- LE (left extremity) AROM (assisted range of motion) in seated, all motions with 2 # GTB (unknown abbreviation), 2 X 15 -- NuStep (recumbent exercise machine) L (level) 2-3 X 10 minutes -- Walk using FWW (front wheel walker), CGA (contact guard assist), gait belt and WC (wheelchair) to following averaging 50 feet per bout. -- Complete 5 X / week. During an interview on 5/27/25 at 2:36 p.m., R7 stated they used to walk me in the hallway, but not anymore, I don't know why. would like to walk in the hallway to stay limber. During an observation on 5/29/25 at 8:47 a.m., R7 was sitting in her recliner. R7 spent most of the day observed in recliner unless she was at meals. During an interview on 5/29/25 at 8:49 a.m., nursing assistant (NA)-D stated the facility used to have a restorative aide, then due to low census	2 890		

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2 890	Continued From page 34 the position was eliminated. NA-D stated NA's were never instructed they were supposed to start doing restorative nursing cares with residents. NA-D stated R7 usually stayed in her room except for church and some music programs. During an interview on 5/29/25 at 9:06 a.m., NA-B stated R7 was on a restorative nursing program and that NA-B did ROM exercises to R7's arms. When asked how NA-B knew what kinds of restorative exercises to do with R7, NA-B stated it was listed in POC (Point of Care) in the EMR. (POC was where NA's looked for individualized tasks/care for residents and documented when completed). During review of R7's POC on 5/29/25, at 9:08 a.m., did not list any restorative nursing functions, including ROM or ambulation. During an interview on 5/29/25 at 10:09 a.m., with the director of nursing (DON) and administrator, the administrator stated the facility used to have a restorative aide - nursing assistant (NA)-C, who went on a leave of absence and didn't return. Her employment ended on 1/14/25. The administrator stated now restorative nursing was done by all NA's, and therapy staff helped, however the DON admitted they had not communicated that to NA's nor trained them how to perform the restorative nursing recommendations from PT. Both the DON and administrator indicated their restorative nursing program stopped when NA-C left. Facility Restorative, Nursing Care Implementation and Screening policy dated 11/27/24, indicated the purpose was to provide appropriate restorative nursing care to each resident, to identify residents appropriate for restorative nursing program. Each resident would receive	2 890		

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2 890	Continued From page 35 restorative nursing care to the extent possible based on individual needs. Restorative aide would be trained in rehabilitation/restorative techniques per job description. The goal of restorative nursing care was to attain and maintain the maximum possible independence and/or prevent rapid declines though their interventions for each resident. Residents were provided appropriate treatment and services to attain/maintain functional abilities of ADLs. The restorative nurse had the overall responsibility and accountability for the restorative program. In the event the location did not have a designated restorative nurse, the responsible and accountability remained with the DON or designee. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures and ensure all residents with limitations in range of motion (ROM) receive services to maintain or improve ROM function. Nursing staff could be educated on the importance of providing services to residents with limited ROM based on assessed needs and as recommended. The DON or designee could develop a monitoring system to audit periodically and report the findings of those audits to the quality assurance performance improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the	2 915		7/9/25

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2 915	Continued From page 36 comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based of observation, interview, and record review, the facility failed to assist with personal hygiene (oral care, shaving) as directed by the plan of care for 2 of 2 resident (R12, R25) reviewed for activities of daily living (ADLs). Findings include: R12's face sheet provided on 5/29/25, included diagnoses of chronic kidney disease and high blood pressure. R12's significant change Minimum Data Set (MDS) assessment dated 5/9/25, indicated R12 had intact cognition, clear speech, could understand and be understood. R12 required assistance with most ADLs. For oral care, the MDS indicated: set up, clean-up assistance;	2 915	Corrected.	

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2 915	Continued From page 37 helper sets up and cleans up; resident completes activity. R12's care plan dated 4/11/25, indicated R12 had an ADL self-care performance deficient related to recent hospitalization as evidenced by weakness and needing rehabilitation. R12's care plan did not include assisting R12 with oral care on a routine and regular basis. R12's Kardex (a reference point in the electronic medical record for nursing staff that provides a summary of a residents care and serves as a documentation tool) printed on 5/29/25, indicated in a section titled AM/PM Care: adjust provision of ADLs to compensate for R12's changing abilities. Encourage participation to the extent R12 wishes to participate. Oral care was not specifically addressed in the Kardex. R12's electronic medical record (EMR), under the TASK tab, was an assignment titled Oral Care. The question staff were to document was, "was oral care provided." Out of 60 opportunities in the past 30 days for R12 to be assisted with oral care (morning and evening), there was only one entry dated 5/18/25, at 8:55 p.m., documented as "refused." During an interview on 5/27/25 at 1:32 p.m., R12 stated, "I never brush my teeth," adding he never asked staff to help him brush his teeth and they didn't ask him. R12 stated everyone was in a hurry to get residents to breakfast in the morning. R12 stated no one offered to help brush his teeth before going to bed either. During an observation on 5/28/25 from 9:08 a.m., to 9:30 a.m., observed nursing assistant (NA)-A provide morning cares, including assisting R12	2 915		

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2 915	Continued From page 38 out of bed and into the bathroom using walker, assisting R12 to sit on the toilet, switched R12's urinary drainage bag to a leg bag, changed his shirt, gave him a warm wash cloth to wash hands and face, wiped buttocks and apply a new brief, combed R12's hair and gave him his eye glasses. At 9:30 a.m., NA-A escorted R12 to the dining room via wheelchair. Oral care was not offered. During an observation and interview on 5/28/25 at 2:10 p.m., R12 was resting in his recliner. Stated no one had helped brush his teeth, and stated he supposed he should brush his teeth. Observed tooth brush in a plastic disposable emesis basis in the cupboard in R12's bathroom. Toothbrush appeared dry; no residual water in basin. During an observation on 5/29/25 at 8:44 a.m., in his bathroom, observed R12's toothbrush appeared to be dry; no residual water in emesis basin. During an interview on 5/29/25 at 9:01 a.m., NA-B verbalized the care she provided to R12 that morning but did not verbalize oral care or brushing teeth. When asked if she assisted R12 to brush his teeth, she stated, yes. NA-B stated she dried the toothbrush with a towel so it wouldn't stain the plastic disposable emesis basin. During an interview on 5/29/25 at 9:05 a.m., R12 stated no one had helped him brush his teeth yet and stated he would like his teeth brushed, adding, I probably have bad breath. During an interview on 5/29/25 at 10:31 a.m., the director of nursing (DON) and administrator were informed of findings, including interviews, observations and document review. The	2 915		

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2 915	Continued From page 39 administrator stated NA's had talked to her about this and told her they definitely did R12's oral care today. The DON and administrator were informed R12 was admitted on 4/11/25, and in the past 30 days, there had been only time where oral hygiene was documented and that was a refusal on 5/18/25. The administrator stated, that is why we tell staff they need to document. R25's face sheet printed 5/29/25, indicated diagnoses of chronic kidney disease, depression, morbid obesity, and diabetes mellitus type II. R25's quarterly MDS assessment dated 5/23/25, indicated intact cognition, no rejection of care, use of wheelchair, and partial/moderate assistance with personal hygiene which included shaving. R25's care plan dated 10/7/24, indicated ADL self-care performance deficit related to impaired mobility, pain, incontinence, and fatigue. Care plan further indicated R25 required setup assistance for personal hygiene. During interview and observation on 5/27/25 at 1:22 p.m., R25 had visible chin hair. R25 state she would prefer chin hair shaved and didn't like how long it was. R25 stated she could not always stand up to look in the mirror. During interview and observation on 5/28/25 at 3:42 p.m., R25 still had long chin hair. R25 stated she was unsure if she had a razor, and no one had offered to assist her with shaving this morning with morning cares. R25 further stated she sometimes asked staff to help her shave her chin, but they would say they were too busy. R25 stated the chin hair really bothered her.	2 915		

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2 915	Continued From page 40 During interview on 5/29/25 at 9:22 a.m., NA-B stated R25 had never had a razor and she had not told a nurse because she would get busy and forget, so she had not been able to shave her. NA-B further stated she knew R25 wanted to be shaved. During interview on 5/29/25 at 9:26 a.m., registered nurse (RN)-A stated she noticed a few days ago R25 needed her chin shaved and was going to trim it but it had slipped her mind. RN-A stated she did not know R25 did not have a razor and would have to work on getting her one. During interview on 5/29/25 at 10:19 a.m., DON stated she was unaware R25 had long chin hair or that she did not have a razor in her room. DON stated she would expect R25 to be shaved if that was her preference. Facility Activities of Daily Living policy dated 12/23/24, indicated the purpose was to provide residents with appropriate treatment and services to maintain or improve abilities in ADLs for the well-being of mind, body, and soul. Any resident who was unable to carry out ADLs would receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. ADLs were those necessary tasks conducted in the normal course of a resident's daily life. Included in these are the following: 1. General Personal, Daily Hygiene/Grooming: Care of hair, hands, face, shaving, applying makeup, skin, nails, and oral care SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable polices and procedures pertaining to completion of resident activities of daily living (ADLs); then inservice direct care staff	2 915		

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2 915	Continued From page 41 on such procedures and audit to ensure ongoing compliance. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control practices were followed for 1 of 1 resident (R12) reviewed for infection control when the tip of urinary drainage tubing was observed laying on the bathroom floor. In addition, the facility failed to clean and maintain reusable urinary drainage bags to minimize the potential for infection for R12. Findings include: R12 face sheet provided on 5/29/25, included diagnoses of urinary retention, hydronephrosis (excess fluid in kidney), flaccid neuropathic bladder (underactive bladder). R12's significant change Minimum Data Set (	21375	Corrected.	7/9/25

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21375	Continued From page 42 MDS) assessment dated 5/9/25, indicated R12 had intact cognition, clear speech, could understand and be understood. R12 had an indwelling urinary drainage catheter and required supervision with most ADLs, including walking. R12's physician orders included: Insert 16 F (French) catheter with 10 ml (milliliter) balloon every 30 days for urinary retention. (There was no order for a leg bag. Facility policy indicated: leg bags may be used with a physician's order). R12's care plan dated 4/28/25, indicated enhanced barrier precautions related to indwelling catheter. The care plan did not identify leg bag or cleaning the overnight urinary drainage bag using vinegar/tap water solution, and the technique to prevent risk of infection. Care plan dated 4/13/25, indicated R12 had an infection of the urinary system and would be free from complications. R12's Kardex printed on 5/29/25, indicated R12 had an indwelling foley catheter. The Kardex did not identify a leg bag or cleaning the overnight urinary drainage bag using vinegar/tap water solution, and the technique to prevent risk of infection. During an observation on 5/27/25 at 11:43 a.m., in R12's bathroom, a gray plastic basin was sitting on the floor next to the toilet/under the sink. In the basin was a large jug of vinegar, a urinal without a cover, and urinary drainage bag. The distal end of the tubing of the urinary drainage bag was setting on the floor, no cap on the end. Two clear plastic graduates were sitting on the handicapped bar next to the sink/toilet. One was dated 1/18/25, and had a catheter tip syringe in it and the other graduate was not dated.	21375		

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21375	Continued From page 43 During an observation and interview on 5/27/25 at 11:48 a.m., nursing assistant (NA)-A who was preparing to empty R12's leg bag was asked to look at the urinary drainage bag in the bathroom. NA-A stated the tubing shouldn't be on the floor because it could cause R12 a bladder infection. NA-A stated the urinary drainage bag was R12's overnight urinary drainage bag. NA-A stated when staff removed it in the morning to attach R12's leg bag, they put half tap water and half vinegar in a graduate, then using the cath-tip syringe put the solution into the distal end of the tubing which then flowed into the bag. During an observation on 5/27/25 at 1:24 p.m., observed the urinary drainage bag tubing still on the bathroom floor. During an observation and interview on 5/27/25 at 1:54 p.m., together with the director of nursing (DON), went to R12's bathroom. The tubing was still on the floor. The DON stated there should be a cap on the end of the tubing; that staff should keep the cap available to reuse it. The DON stated the jug of vinegar, and the urinal shouldn't be in the basin - just the drainage bag with tubing coiled up in it. The DON set the jug of vinegar on the floor and threw away the urinary drainage bag as well as the urinal. The DON stated the urinary drainage bag was changed weekly along with the graduate and syringe. The DON acknowledged according to the date; the graduate had been in use longer than a week. The DON also acknowledged the potential for R12 to obtain a urinary tract infection (UTI) had the contaminated tubing been reattached to his urinary catheter after having laid on the floor. During an observation and interview on 5/28/25 at 9:20 a.m., observed NA-A empty the urine from	21375		

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21375	Continued From page 44 R12's overnight urinary drainage bag into the toilet. Next, using water from the faucet, NA-A put water in the graduate, then added an approximately equal amount of vinegar for a total of about 200 ml (milliliters). Using a cath tip syringe, NA-A drew up the solution and injected it into the distal tip of tubing of the urinary drainage bag. The solution went into bag. NA-A then capped the distal tip and set the urinary drainage bag in the basin and coiled the tubing on top of the bag. NA-A stated the solution was kept in bag until the bag was used again at night. During an observation and interview on 5/28/25 at 3:30 p.m., together with registered nurse (RN)-B who was also the infection preventionist, went to R12's bathroom. After observing the urinary drainage bag in the basin on the floor, the jug of vinegar, graduate and syringe, RN-B stated she was unaware of the practice of NA's using tap water and vinegar to flush the overnight urinary drainage bags. RN-B stated the organization was looking at ways to reduce urinary tract infections by maintaining a closed catheter system. During an observation on 5/29/25 at 8:44 a.m., observed the overnight urinary drainage bag in the basin on the floor in R12's bathroom. The distal tip of tubing was uncapped and on top of bag and the cap was sitting on another part of the bag. During an interview on 5/29/25 at 10:31 a.m., with the DON and administrator, informed them of findings, including the observation of the uncapped tip of the urinary drainage bag from that morning. The DON stated one of their performance improvement projects was on UTI's. Was aware R12 had a recent UTI.	21375		

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21375	Continued From page 45 Facility Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen policy dated 4/6/25, indicated: --All closed collection systems that become contaminated by inappropriate technique, leaks or other means are immediately replaced. --Leg bags may be used with a physician's order. --Catheter tubing should never be allowed to touch the floor. --To clean the bag not in use: Be sure to close the bottom port of the bag that was emptied and not in use. Rinse the bag with warm (not hot) soapy water or bacteriostatic solution such as one-part white vinegar and three parts water solution or an appropriate commercial solution. Pour solution into the bag. Swish the solution around being sure to get the corners of the bag. Hint: A 60 ml syringe may be used to get solution into bag, be sure to clean the tip of the syringe with alcohol wipe before use and store in clean dry place. Soak the bag for 30 minutes. Open the bottom drainage port and drain the solution from the bag. Rinse the bag with warm water and hang to dry in the residents restroom covered with a clean towel. g. Cover/cap the tubing once the bag is dry. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures related to proper infection control practices when cleaning and maintaining reusable urinary drainage bags to minimize the potential for infection. The DON or designee could then educate and train nursing staff on these practices. The DON or designee could develop a monitoring system to audit periodically and report the findings of those audits to the quality assurance performance improvement (QAPI) committee to ensure compliance and determine the need for further	21375		

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21375	Continued From page 46 improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		