DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 4, 2025

Administrator
Good Samaritan Society - Blackduck
172 SUMMIT AVENUE WEST
BLACKDUCK, MN 56630

RE: CCN:245600
Cycle Start Date: August 20, 2025

Dear Administrator:

On August 20, 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 November 20, 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 February 20, 2026 (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,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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Re: State Nursing Home Licensing Orders
Event ID: 1D0C35H

Dear Administrator:

The above facility survey was completed on August 20, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245600	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Blackduck	172 SUMMIT AVENUE WEST , BLACKDUCK, Minnesota, 56630

(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
E0000	Initial Comments On 8/18/25-8/20/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements 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.	E0000		09/24/2025
F0000	INITIAL COMMENTS On 8/18/25-8/20/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H56002322C (iQIES 1171529). No deficiencies were cited. 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.	F0000		09/24/2025
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F0605	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,	09/24/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245600	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

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F0605 SS = D	Continued from page 1 §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An	F0605	Continued from page 1 this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F605 Right to be free from chemical restraints. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R26's request for gradual dose reduction of Trazodone was sent to his Primary M.D. on 9/10/2025. R7 was seen by her Primary M.D. on 7/18/2025 and noted that no tapers were recommended as previous attempts have resulted in significant mental duress and she would concur with psychiatry to continue current dosing. An appointment was set up with psychiatry for 8/25/2025 to review R7 Olanzapine and Sertraline, however the resident refused to attend that appointment. The appointment was rescheduled for 9/11/2025. On 9/11/2025 psychiatry reduced the noon dose of Olanzapine. Psychiatry did not want to make more than one change at this time and would like an update in three weeks. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents in the facility have the potential to be affected by the deficient practice. As a result, all residents on psychotropic medications will be reviewed to ensure their gradual dose reductions have been addressed or requested as appropriate by 9/24/2025. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, the facilities Psychotropic Medication policy was reviewed by DNS/designee on 9/11/2025. Also, the facilities IDT team, licensed, and registered nurses will be educated on the Psychotropic Medication policy to ensure freedom from unnecessary drugs is addressed per regulations. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is sustained, the DNS/designee will audit 4 residents on Psychotropic Medications weekly to ensure the facilities Psychotropic Medication Policy is being followed and gradual dose reductions	

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F0605 SS = D	Continued from page 2 unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner	F0605	Continued from page 2 are being requested timely. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease or discontinue audits. 5. What is the date of completion? Compliance date: 9/24/2025	

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F0605 SS = D	Continued from page 3 evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure there was a comprehensive assessment and monitoring for prescribing a psychotropic medication for sleep for 1 of 6 (R26); and failed to provide evidence a gradual dose reduction (GDR) or a clinical justification of a psychotropic medication was completed for 1 of 6 residents (R26, R7) reviewed for unnecessary medication and were taking psychotropic medications. Findings include: R26's quarterly Minimum Data Set (MDS) dated 7/2/25, identified R26 had a moderate cognitive impairment and had diagnoses that included dementia. R26 used antidepressant medication daily. R26's Order Summary Report dated 1/28/25, identified Trazodone HCl oral tablet (an antidepressant primarily used to treat major depressive disorder. It works by increasing serotonin levels in the brain, which can help improve mood, appetite, and energy levels, as well as reduce anxiety and insomnia related to depression. Additionally, trazodone is sometimes prescribed as a sleep aide due to its sedative effects, and it is considered non-addictive.) give 25 milligrams (mg) at bedtime related to unspecified dementia, moderate, with other behavioral disturbance with a start date of 1/28/25. R26's medication record failed to identify R26's sleep was assessed prior to starting Trazodone or after starting the medication to ensure it was effective. R26's care plan revised 2/23/25, identified R26 was on antidepressant medication therapy related to depression. Staff were directed to: Monitor R26's condition based on clinical practice guidelines or clinical standards of practice related to the use of Trazodone, and Consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate. R26's nursing note(s) identified the following: 6/26/25 at 3:46 p.m., identified the Mood/Behavior Committee met and reviewed R26's behavior/mood monitoring: hallucinations/delusions. R26's care plan	F0605		

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F0605 SS = D	Continued from page 4 and interventions were reviewed and continued to be appropriate. R26 had been sleeping a lot more lately. The note failed to identify if R26's sleep was monitored for potential side effects. 7/2/25 at 4:55p.m, identified R26 had a diagnosis of Dementia with Psychotic Disturbances and Dementia with Behavioral disturbances. R26 was alert although not always orientated. At times, R26 had thoughts that he needed to go to Blackduck and that he was not here already. Other times, R26 was fine. PHQ-9 Scored a 03 compared to 00 on last one. R26 said he was tired all the time. R26 answered all questions for interviews. There were no incidents over quarter. Staff were monitoring hallucinations and/or delusions. R26 had 60 occurrences over the quarter. There was four days in the look back period where R26 was confused where he was and got verbally aggressive with staff on one and was hollering out unsure where he was at. All four days involved not knowing where he was. Per staff interview, intervention remained appropriated. IDT Team and Behavior Committee just met and R26's mood/behavior monitoring continued to be appropriate. The note failed to identify if R26 had a sleep assessment and/or if R26's sleep was monitored for potential side effects. R26's Consultant Pharmacist's Medication Review dated 7/11/25, identified R26 was prescribed Trazodone 25 mg at bedtime since 1/28/25. Per CMS guidelines, all psychotropic medications should be considered for a trial dose reduction at least twice within the first year of use. If a dose decrease is contraindicated, rigorous risk/benefit documentation should be provided. A review of recent provider progress notes did not yield a thorough risk/benefit assessment for this patient's psychotropic medications. Suggested course of action: Please evaluate the above psychotropic medications and consider reducing either the trazodone dose on a trial basis or provide clear clinical documentation as to why a dose reduction is contraindicated at this time. However, the form failed to identify a response from R26's physician. R26's medical record failed to identify R26's provider was contacted regarding R26's Trazodone and/or pharmacist's recommendations. R26's care conference note dated 7/22/25 at 1:30 p.m., identified R26 was sleeping and could not wake up. Could not ask R26 or family questions. R26 did a lot of sleeping during the day. Going to talk to the doctor about if he still needs the trazodone. The note failed to identify any further action.	F0605		

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F0605 SS = D	Continued from page 5 During an observation on 8/18/25 at 3:20 p.m., R26 was lying in bed asleep. R26 was sleeping since survey entrance and did not wake when greeted. During an observation on 8/19/25 at 8:34 a.m., R26 was in his room sitting reclined with his feet up in his wheelchair. Blankets covered R26 to his chin. R26's eyes were closed and did not respond when greeted. During an observation on 8/19/25 at 3:42 p.m., R26 was lying in bed asleep on his right side. R26 did not respond when greeted. During an observation on 8/20/25 at 7:32 a.m., R26 was lying in bed with the head of the bed elevated. R26 was covered to his chin with blankets. R26 was asleep and looked up when greeted but laid his head back down and closed his eyes. During an interview on 8/20/25 at 8:50 a.m., nursing assistant (NA)-D stated R26's eyesight was poor. R26 used to make comments like the sun was out but R26 didn't even do that anymore. R26 was pretty set in his ways but R26 did sleep a lot. During an interview on 8/20/25 at 11:08 a.m., registered nurse (RN)-A stated R26 was "pretty much like that": pretty laid back, relaxed and slept a lot. RN-A stated he was surprised R26 was on Trazodone because R26 slept a lot, and Trazodone would make R26 even more tired. The only sleep assessment ever conducted for R26 was on 4/4/16. RN-A could not determine why R26 was started on Trazodone and, normally, there was documentation to show why a medication like that was started. When a resident was taking a medication like Trazodone a sleep assessment should be done at least annually if not more often. During an interview on 8/20/25 at 11:28, the director of nursing (DON) stated she believed she missed R26 had an appointment with his physician, or she would have requested R26's Trazodone be discontinued. The DON preferred as many medication requests were done during appointments as possible because faxed requests usually did not generate a response. During an interview on 8/20/25 at 3:44 p.m., the consultant pharmacist stated, in general, after a resident was taking Trazodone for 6 months, a gradual dose reduction (GDR) was recommended. During an interview on 8/20/25 at 3:14 p.m., social services designee (SSD)-A stated she completed the	F0605		

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F0605 SS = D	Continued from page 6 annual and quarterly MDS for sections C, D, and F. If there was a Care Area Assessment (CAA) for activities, SSD-A completed that as well. If a resident was on a medication for sleep, SSD-A entered a sleep study as well. SSD-A looked at the diagnosis on the medication sheet and if it stated the medication was for sleep, that would indicate a sleep study was needed. For R26, the medication diagnosis was for hallucinations, and a sleep study was not done. SSD-A stated, for side effects, a sleep assessment was a nursing responsibility. During an interview on 8/20/25 at 3:40 p.m., the DON stated she believed SSD-A did a sleep study for all residents on Trazodone, whether prescribed for sleep or not, because it has a sedating effect. “We need to improve our communication.” The DON stated a any drug that affected brain activities associated with mental processes and behavior could be considered a chemical restraint and it should be monitored appropriately, and our documentation should show the rationale for use. It should be a team approach and never one nurse requesting a medication like that. Staff should always try other interventions first. During an interview on 8/20/25 at 3:44 p.m., the consultant pharmacist stated, in general, after a resident was taking Trazodone for 6 months, a gradual dose reduction (GDR) was recommended. During that time, the staff should be monitoring the resident and documenting the resident was benefitting from the medication. If for sleep, for example, the resident should be sleeping better. If for mood, it should be controlling their mood. However, staff should be monitoring for side effects of Trazodone because Trazodone could be very sedating. During an interview on 8/20/25 at 4:26 p.m., the administrator stated he expected staff to follow facility policy and procedure. R7’s quarterly MDS dated 7/1/25, identified R7 had moderate cognition. Diagnoses included obsessive-compulsive disorder (mixed obsessional thoughts and acts), dementia, anxiety, depression and psychotic disorder. R7 received antipsychotics on a routine basis. A gradual dose reduction (GDR) had not been attempted or had not been documented by a physician as clinically contraindicated. R7’s physician orders identified an order for olanzapine (antipsychotic medication) to be given twice daily related to depression and was started 1/19/23. R7	F0605		

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F0605 SS = D	Continued from page 7 also received Sertraline given one time a day for depression with psychotic symptoms and was started 6/5/22. R7's medical record lacked evidence a GDR had been attempted or identified a medical justification the resident was on the lowest effective dose within the past calendar year for the olanzapine or sertraline. R7's provider nursing home rounds report dated 7/18/25, identified psychiatry followed R7 for anxiety, major depression, dementia with behavioral disturbance, and obsessional thoughts/acts. The note identified R7 had failed previous attempts of medication tapers although failed to identify what medications were tapered and when the medications were tapered. R7's behavioral health visit note dated 7/30/24, identified R7 was to return to the clinic in 6 months or sooner, and continue olanzapine twice daily and sertraline daily. The note failed to identify if the medications were the lowest effective dose or if a GDR should be attempted. On 8/20/25 at 3:33 p.m., the DON stated R7's last psychology visit was more than a year ago and R7 had failed previous attempts for GDR's, however, the DON couldn't remember when GDR was attempted or if they were documented in R7's medical record. The DON stated she thought R7's primary provider was following the residents psych medications but was uncertain since it wasn't documented in the medical record. On 8/20/25 at 4:21 p.m., a message was left for the consulting pharmacist (CP) requesting return call. The facility policy Psychotropic Medications revised 5/12/25, identified throughout the administration of a psychotropic medication, the following must be completed, Mood and behavior documentation must continue to monitor the effect the medication has on the behavior, Monitor for side effects of the medication. If a side effect occurs or worsening of a known side effect is noted, the nurse will make a note in the electronic medical record (EMR) and notify the physician and family/legal representative of this change in condition., Monitor for effectiveness and potential adverse consequences., Gradual dose reductions must be done according to federal regulations. For the guidelines for dose reductions, see the Gradual Dose Reductions section of this procedure, The reduction committee will review the need for psychotropic medications at least every three months and document the rationale for continuing the	F0605		

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F0605 SS = D	Continued from page 8 medication. The committee also will need to evaluate: The resident's target symptoms and the effect of the medication on the severity, frequency and other characteristics, Any changes in the resident's function during the last quarter; this can be done by reviewing the MDS, Whether the resident experienced any medication-related adverse consequences during the previous quarter, and Fax the Fax Communication to Physician to the prescriber. Scan the completed form into OnBase as part of the medical record.	F0605		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning for 1 of 3 residents (R2) reviewed for pressure ulcers. Findings include: R2's quarterly Minimum Data Set dated 6/8/25, identified R2 had moderate cognitive impairment. Diagnoses included dementia, renal insufficiency and anemia. R2 was at risk of pressure injury/ulcer and required substantial/maximal assistance for bed mobility and was dependent on staff for transfers. R2's Braden Scale for Predicting Pressure Sore Risk dated 5/28/25, identified R2 was at high risk for pressure injury/ulcer. R2's care plan revised 5/29/24, included interventions	F0686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A Braden Scale for Predicting Pressure Score Risk for R2 was completed on 9/11/2025. R2's Care Plan and Kardex in PCC-POC has been updated to reflect R2's individualized interventions to prevent/heal pressure ulcers. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents in the facility have the potential to be affected by the deficient practice. As a result, a review of each residents' Braden Scale will be completed. Each residents' Care Plans and Kardex in PCC-POC will be updated to ensure appropriate interventions are in place to prevent/heal pressure ulcers. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, the facilities policy Skin Assessment Pressure Ulcer Prevention and Documentation Requirements was reviewed by DNS/designee on 9/11/2025. All licensed and registered nurses will be educated on the facilities policy Skin Assessment Pressure Ulcer Prevention and Documentation Requirements. All nursing staff will be educated to follow each residents Kardex in PCC-POC detailing the individualized interventions in place to prevent/heal pressure ulcers. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is sustained, the DNS/designee,	09/24/2025

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F0686 SS = D	Continued from page 9 to check and reposition R2 frequently during the day, 12:00 a.m. and 4:00 a.m. at night; turn from Side to Side: R2 required substantial/max assist of 1 staff member for turning side to side in bed with use of bilateral grab bars on bed. - During a continuous observation on 8/20/25 at 7:18 a.m., R2 was lying in bed. R2's head of bed (HOB) was approximately elevated to 30 degrees and R2's tv was on. R2's overbed table was in front of R2. R2 was rubbing her eyes and stated she was tired that morning. At 7:20 a.m., nursing assistant (NA)-E stepped into R2's room and stated R2 wanted to eat breakfast in her room that morning. NA-E requested R2's breakfast order then raised R2's HOB so R2 was sitting upright. NA-E did not offer or reposition R2 before leaving the room. At 7:42 a.m., R2's breakfast tray was delivered and set up by kitchen staff. At 8:00 a.m., NA-C stepped into R2's doorway and asked R2 if she was "doing ok". R2 was eating her breakfast. NA-C did not offer or reposition R2. At 8:53 a.m., R2 continued to sit in the same position. R2's finished breakfast remained in front of her on the overbed table. At 9:46 a.m., NA-F entered R2's room and told R2 NA-F was going to "check her". NA-F removed R2's breakfast tray, performed incontinence cares and transferred R2 to her wheelchair with the full body mechanical lift and NA-E. - During an interview on 8/20/25 at 9:58 a.m., NA-F stated R2 needed to be turned and/or repositioned every two to three ours. During an interview on 8/20/25 at 10:02 a.m., NA-B and NA-C stated R2 needed to be turned and repositioned every two hours. NA-B stated the electronic point of care (POC) module directed the staff when residents were due and, once completed, the nursing assistants signed it off. NA-C stated she did R2's cares that morning before 7:00 a.m. and stopped into R2's room at 8:00 a.m. to reposition R2 but R2 was eating. However, NA-C did not offer to reposition R2 nor returned to R2's room after R2 was finished eating. NA-C stated someone should have. During an interview on 8/20/25 at 11:11 a.m., registered nurse (RN)-A stated R2 was at risk for pressure injury/ulcer and the nursing assistants should have offered to turn and reposition R2 was she was done eating breakfast. During an interview on 8/20/25 at 11:31 a.m., the director of nursing (DON) stated R2 typically had morning cares between 6:00 a.m. and 7:00 a.m. R2 liked to stay in bed for breakfast and the nursing would get	F0686	Continued from page 9 the Director of Nursing or Designee will audit 4 residents weekly to ensure Braden Scales are completed, Care Plans and Kardex's are updated to reflect interventions in place to prevent/heal pressure ulcers, and that turning and repositioning is being completed timely by nursing staff. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease or discontinue audits. 5. What is the date of completion? Compliance date: 9/24/2025	

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F0686 SS = D	Continued from page 10 R2 up into her wheelchair later in the morning. The DON stated staff should have offered to turn and reposition R2 approximately a half hour after eating. During an interview on 8/20/25 at 4:26 p.m., the administrator stated he expected staff to follow policy and procedure. The facility policy revised 4/6/25, identified Residents who are unable to reposition themselves independently, as indicated on the Sit-Stand-Walk Data Collection Tool UDA, should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is required for those residents unable to position themselves and is based on nutrition, hydration, incontinence, diagnoses, mobility and observation of the resident's skin over a period of time. The Positioning Assessment and Evaluation UDA is a required tool that is used to determine an individualized repositioning plan. The positioning schedule should be communicated to the nursing assistants using the Kardex in PCC-POC. Any resident at risk will be placed on a pressure redistribution surface as determined appropriate.	F0686		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to assess and analyze a resident fall with major injury to identify specific hazards and/or risks and to develop targeted interventions to reduce the potential for falls for 1 of 1 resident (R27) reviewed for falls. Findings include: R27's resident event form dated 8/8/25 at 4:45 p.m., identified on 8/8/25 R27 was observed peddling himself with his feet in the hallway, became tangled up in a	F0689	F689 Free of Accident Hazards/Supervision/Devices 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A comprehensive assessment by the IDT Team was completed on 9/11/2025 for R27's fall that took place on 8/8/2025 to include causal factors and/or root cause. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents in the facility have the potential to be affected by the deficient practice. As a result, a comprehensive assessment by the IDT Team was completed on 9/11/2025 for all residents that have fallen since 8/1/2025 to ensure causal factors and/or root cause was identified. A falls tool assessment will be completed on all residents by 9/24/2025. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, the facilities Fall Prevention and Management policy reviewed was reviewed by the DNS/designee on 9/11/2025.	09/24/2025

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F0689 SS = D	Continued from page 11 computer table and fell out of his wheelchair. The wheelchair then fell on top of the resident. No immediate intervention put into place and unknown if there was an injury. R27's progress notes dated 8/11/25 at 4:50 p.m., identified R27 had a fall on 8/8/25 with a hip fracture and was currently in the hospital after hip nailing. Anti-roll backs would be applied to resident's wheelchair. However, the note failed to identify a description or cause of R27's fall. R27's falls tool report dated 8/15/25, identified R27 was at risk for falls related to an actual fall on 8/8/25, was taking 2 or more at risk medications, had moderately impaired cognition, reduced insight, delirium, poor memory and was impulsive. However, the tool failed to identify a description of or cause of R27's fall on 8/8/25. R27's care plan reviewed 8/18/25, identified R27 required staff assistance to transfer with a non-mechanical stand aide and did not ambulate. R27 had an actual fall with major injury and safety interventions included staff to remind resident not to bend over to pick up dropped items, use call light for assistance and keep personal items within reach. R27's medical record failed to identify a comprehensive assessment following the fall on 8/8/25, to include causal factors and/or root cause of R27's in an attempt to prevent further falls. R27's Medicare 5-Day Minimum Data Set (MDS) dated 8/20/25, identified R27 was readmitted to the facility on 8/14/25, after an acute hospital stay. R27 was cognitively intact, required staff assistance with activities of daily living (ADL's), and had diagnoses including surgical repair of the right hip after a fall with major injury on 8/8/25. On 8/20/25 at 11:20 a.m., nursing assistant (NA)-E stated R27 had a fall recently when the resident reportedly fell in the lobby and fractured the right hip. Upon return from the hospital, R27 required more assistance with ADL's, couldn't stand on his own, and didn't call for help as much as previous. Staff used the manual sit-to-stand lift (a mobility aide designed to assist individuals in transitioning safely from sitting to standing) for all transfers. On 8/20/25 at 2:25 p.m., registered nurse (RN)-A stated R27 fell on 8/8/25, thought a note was entered in the EMR and remembered talking about the fall, although,	F0689	Continued from page 11 The IDT Team, licensed and registered nurses, will be educated on the facilities Fall Prevention and Management policy to ensure a comprehensive assessment is completed for each resident fall to include causal factors and/or root cause. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is sustained, the DNS/designee, the Director of Nursing or Designee will audit all residents falls weekly to ensure comprehensive assessment is completed for each resident fall to include causal factors and/or root cause. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease or discontinue audits. 5. What is the date of completion? Compliance date: 9/24/2025	

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F0689 SS = D	Continued from page 12 upon request RN-A was unable to find documentation regarding the residents fall or discussions related to the fall. Further, RN-A stated R27's fall was not documented in the EMR. On 8/20/25 at 2:43 p.m., the DON stated the interdisciplinary team (IDT) met every Wednesday morning to discuss high risk incidents including resident falls. On 8/13/25 at 9:56 a.m., there was a note in the resident's chart identifying the IDT team met and discussed the residents fall, although the note failed to identify causal factors of the fall. The DON stated upon readmission, R27 had a fall tool was completed, although was uncertain what the assessment entailed or if the fall was assessed or analyzed to determine causal factors or a root cause. The DON stated interventions to prevent further falls included anti-roll backs on R27's wheelchair. The DON stated R27's fall was probably not documented in the medical record. The facility Fall Prevention and Management policy reviewed 4/8/25, included after stabilizing a resident from a fall with major injury, the nurse would complete a fall scene huddle worksheet, initiate an investigation into the fall, update the careplan, and document in Riskonnect. The completed fall scene huddle worksheet would be given to the fall committee chair or designee for review and follow-up.	F0689		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is	F0690	F690 Bowel/Bladder Incontinence, Catheter, UTI 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Physician orders for indwelling urinary catheter were obtained on 8/21/2025. A dignity bag has been placed in this residents room to prevent his catheter bag from coming in contact with the floor. NA-D was educated on 8/18/2025 and again on 8/31/2025 on correct catheter care and hand hygiene. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents in the facility have the potential to be affected by the deficient practice. Specifically all residents with indwelling urinary catheters were reviewed to ensure appropriate orders were in place. Dignity bags were placed in resident rooms for all residents with catheters to prevent catheter bags from coming in contact with the floor.	09/24/2025

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F0690 SS = D	Continued from page 13 assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a physician order for indwelling urinary catheter; and failed to ensure urinary catheter care was provided in a manner to prevent contamination and potential urinary tract infection (UTI) for 1 of 4 residents (R4) reviewed for urinary catheter. Findings include: R4's quarterly Minimum Data Set (MDS) dated 7/1/25, identified R4 had a severe cognitive impairment and had diagnoses that included hematuria, neuromuscular bladder dysfunction (nerve damage that affects bladder control), reflux uropathy (the backward flow of urine from your bladder into your kidneys. Without treatment, the condition could lead to complications such as high blood pressure and chronic kidney disease.), type 2 diabetes, dementia and a methicillin resistant staphylococcus aureus (MRSA). R4 used an indwelling urinary catheter. R4's care plan revised 4/18/25, identified R4 had an indwelling catheter due to urinary retention and obstruction. Staff were instructed to:, Monitor/document for pain/discomfort due to catheter, Document intake and/or output., Monitor/document for pain/discomfort due to catheter, and Monitor/record/report to health care provider for signs/symptoms of urinary tract infection (UTI): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased R4's Interagency Handoff Report dated 7/8/25, identified R4 was hospitalized due to kidney stones and	F0690	Continued from page 13 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, the facilities policy Catheter Care: Insertion and Removal, Drainage Bats, Irrigation, Specimen was reviewed by DNS/designee on 9/11/2025. All licensed and registered nurses will be educated on the facilities policy Catheter Care: Insertion and Removal, Drainage Bats, Irrigation, Specimen. All nursing staff will be educated on catheter care and hand hygiene. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is sustained, the DNS/designee, the Director of Nursing or Designee will audit three residents weekly to ensure appropriate orders are in place for indwelling catheters, and that proper catheter care and hand hygiene is used when caring for these residents. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease or discontinue audits. 5. What is the date of completion? Compliance date: 9/24/2025	

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F0690 SS = D	Continued from page 14 had ureter stents placed. R4's indwelling catheter was replaced while hospitalized on 7/1/25 with a 24 French (FR) foley catheter with a 60 milliliter (ml) balloon. The report failed to identify an order for continued urinary catheter use. R4's Order Summary report dated 8/21/25, identified maintain 20 FR coude catheter (a urinary catheter with a curved tip) with 30 ml balloon. Change every 14 days and as needed for obstruction at bedtime every 2 weeks related to urinary retention and obstruction was discontinued on 7/8/25. R4's nursing progress note dated 7/22/25 at 3:11 p.m., identified R4 had a follow-up Urology appointment on 7/21/25 and R4 was scheduled for further imaging of his kidneys and a follow-up Urology appointment with the provider who performed R4's procedure. The note failed to identify an order was received for continued urinary catheter use. R4's nursing progress note dated 8/3/25 at 7:52 a.m., identified R4's indwelling foley catheter was replaced with a 20 FR foley catheter with a 5 ml and urinary catheter bag falling apart. R4's prior catheter was intact but had a blood clot on the tip blocking urine flow. The note failed to identify if a provider was contacted to obtain an order for replacement. During an observation on 8/18/25 at 6:44 p.m., nursing assistant (NA)-D assisted R4 with evening cares. NA-D wore gown, and gloves. When finished, NA-D hung R4's urinary catheter bag on the bedframe and lowered R4's bed to the floor. R4's urinary catheter bag port was not fastened to the holder and the bag rested on the floor. At 6:57 p.m., NA-D removed her soiled gloves, used hand sanitizer and put on new gloves. NA-D obtained a graduate from R4's closet and placed the graduate under R4's urinary catheter bag. NA-D drained approximately 500 cc of urinary from the bag then closed and cleaned the port with an alcohol wipe. NA-D poured the graduate into the toilet and set the graduate down. NA-D removed her gloves, washed her hands, then put on new gloves. NA-D then picked up the soiled graduate and placed it back into the closet. However, NA-D did not remove her soiled gloves. At 7:03 p.m., NA-D removed R4's teeth from his denture cap and placed them in R4's mouth. NA-D removed her soiled gloves/gown and used hand sanitizer before leaving the room. However, R4's urinary catheter bag remained on the floor.During an interview on 8/18/25 at 7:09 p.m., NA-D stated she did take off her gloves and wash her hands before putting away the graduate, but did not change her gloves before assisting R4 with his dentures	F0690		

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F0690 SS = D	Continued from page 15 because she thought the outside of the graduate was clean. Also, NA-D stated she left the urinary catheter bag touching the floor and R4 needed his bed lowered for safety. NA-D stated the urinary catheter bag should not lie on the floor because the floor was dirty, and it could lead to R4 getting an infection. During an interview on 8/20/25 at 11:12 a.m., registered nurse (RN)-A stated R4 had an order for his catheter before R4 was hospitalized but did not have a current order. RN-A stated he did see the note where R4's catheter was changed, and an order should have been obtained prior to changing. Also, when R4 returned from the hospital, the admitting nurse should have contacted R4's provider for further direction. Further a resident's catheter bag should never rest on the floor. The catheter bag should either be clipped higher or put in a cloth bag for basic hygiene and to keep the floor and catheter bag sanitary. Staff were expected to remove soiled gloves and wash hands prior to doing oral cares. During an interview on 8/20/25 at 1:19 p.m., the director of nursing (DON) stated the facility had a new policy to not flush or change a catheter unless there was a problem. R4 used to have weekly catheter changes and as needed. R4 returned to the facility with a 24 FR coude catheter and there was no order for weekly catheter changes, however, the DON was unaware R4 did not have an order for changes as needed. The staff should have ensured there was an order before changing the catheter on 8/3/25. The DON had worked the night shift on 8/3/25 and the day nurse said she could change R4's catheter and the DON went home. The DON stated she did not verify R4's orders. Further, a barrier should have been placed under R4's urinary catheter bag or the urinary catheter bag placed into a cloth bag to prevent infection. The nursing assistants are trained to removed soiled gloves and wash their hands prior to doing oral cares. During a telephone interview on 8/20/25 at 3:32 p.m., the urologist stated he had only evaluated R4 the one time postoperatively. The urologist didn't have enough data from R4's hospital stay to be able to fully care for R4. Because of that, he referred R4 back to urologist who performed R4's procedure and ordered a follow up CT to ensure they had all the possible information for that appointment. For the urinary catheter, the urologist stated he could not determine why R4 had a 24 FR coude catheter with a 60 ml balloon was placed after R4's procedure. Because of that, he would expect staff to contact the discharging physician to obtain further direction and to follow orders as	F0690		

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F0690 SS = D	Continued from page 16 given. During an interview on 8/20/25 at 4:26 p.m., the administrator stated he expected staff to follow facility policy and procedure The facility policy Catheter Care: Insertion and Removal, Drainage Bags, Irrigation, Specimen revised 4/6/25, identified the following: Catheters will be inserted only with a physician's order and will include the type of catheter, size and balloon capacity for indwelling catheter. Catheter tubing should never be allowed to touch the floor. Non-obstructed “downhill” flow is always maintained. PROCEDURE Emptying Catheter Drainage Bag Equipment 1. Perform beginning five and apply gloves. 2. If splashing or spraying is anticipated use personal protected equipment (PPE). 3. When emptying the catheter bag, place a fluid-impermeable pad beneath the measuring container and avoid placing the container on the floor. 4. Open drainage port and allow urine to drain into measuring container placed underneath. Do not allow tip of tubing to touch sides of the measuring container or any surface. 5. When done, clean drainage port tip with alcohol wipe and replace in the holder. 6. Make sure the drainage bag and tubing are appropriately placed. 7. In rehabilitation/skilled care, if resident is on Intake and Output measure urine volume and record in PCC-POC/EMR. 8. Discard urine in toilet. 9. Wash and dry measuring container according to location procedure. Do not store the measuring container on the floor. 10. Perform ending five. 11. Note amount and character of urine. Report any significant observations to licensed nurse (blood, mucous, low urine output).	F0690		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On	F0756	F756 Drug Regimen Review, Report Irregular, Act On	09/24/2025

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F0756 SS = D	Continued from page 17 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist recommendations were addressed and acted upon and documented in the medical record for 2 of 5 residents (R26, R7) reviewed for unnecessary medications.	F0756	Continued from page 17 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Pharmacy recommendations for R26 and R7 have been reviewed. R26's request for gradual dose reduction of Trazodone was sent to his Primary M.D. on 9/10/2025. R7 was seen by her Primary M.D. on 7/18/2025 and noted that no tapers were recommended as previous attempts have resulted in significant mental duress and she would concur with psychiatry to continue current dosing. An appointment was set up with psychiatry for 8/25/2025 to review R7 Olanzapine and Sertraline, however the resident refused to attend that appointment. The appointment was rescheduled for 9/11/2025. On 9/11/2025 psychiatry reduced the noon dose of Olanzapine. Psychiatry did not want to make more than one change at this time and would like an update in three weeks. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents in the facility have the potential to be affected by the deficient practice. As a result the consulting pharmacist recommendations have been reviewed for all residents and gradual dose reductions will be requested as appropriate by 9/24/2025. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained , the facilities Medication: Drug Regimen Review policy was reviewed by DNS/designee on 9/11/2025. The Director of Nursing, MDS Nurse, and HIM will be educated on the facilities Medication: Drug Regimen Review policy by 9/24/2025 to ensure timely follow-up to consultant pharmacist recommendations. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is sustained, the DNS/designee , the Director of Nursing or Designee will audit pharmacy recommendations monthly to ensure timely follow-up to consultant pharmacist recommendations. . Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease or discontinue audits.	

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F0756 SS = D	Continued from page 18 Findings include: R26's quarterly Minimum Data Set (MDS) dated 7/2/25, identified R26 had a moderate cognitive impairment and had diagnoses that included dementia. R26 used antidepressant medication daily. R26's Order Summary Report dated 8/21/25, identified Trazodone HCl oral tablet (an antidepressant primarily used to treat major depressive disorder. It works by increasing serotonin levels in the brain, which can help improve mood, appetite, and energy levels, as well as reduce anxiety and insomnia related to depression. Additionally, trazodone is sometimes prescribed as a sleep aide due to its sedative effects, and it is considered non-addictive.) give 25 milligrams (mg) at bedtime related to unspecified dementia, moderate, with other behavioral disturbance was started on 1/28/25. R26's Consultant Pharmacist's Medication Review dated 7/11/25, identified R26 was prescribed Trazodone 25 mg at bedtime since 1/28/25. Per CMS guidelines, all psychotropic medications should be considered for a trial dose reduction at least twice within the first year of use. If a dose decrease is contraindicated, rigorous risk/benefit documentation should be provided. A review of recent provider progress notes did not yield a thorough risk/benefit assessment for this patient's psychotropic medications. Suggested course of action: Please evaluate the above psychotropic medications and consider reducing either the trazodone dose on a trial basis or provide clear clinical documentation as to why a dose reduction is contraindicated at this time. However, the form failed to identify a response from R26's physician. R26's medical record failed to identify R26's provider was contacted regarding R26's Trazodone and/or pharmacist's recommendations. During an interview on 8/20/25 at 11:28, the director of nursing (DON) stated she believed she missed R26 had an appointment with his physician, or she would have requested R26's Trazodone be discontinued. The DON preferred as many medication requests were done during appointments as possible because faxed requests usually did not generate a response. During an interview on 8/20/25 at 3:44 p.m., the consultant pharmacist stated, in general, after a resident was taking Trazodone for 6 months, a gradual dose reduction (GDR) was recommended. During an interview on 8/20/25 at 4:26 p.m., the	F0756	Continued from page 18 5. What is the date of completion? Compliance date: 9/24/2025	

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F0756 SS = D	Continued from page 19 administrator stated he expected staff to follow facility policy and procedure. R7's quarterly MDS dated 7/1/25, identified R7 had moderate cognition. Diagnoses included obsessive-compulsive disorder (mixed obsessional thoughts and acts), dementia, anxiety, depression and psychotic disorder. R7 received antipsychotics on a routine basis, a gradual dose reduction (GDR) had not been attempted or had not been documented by a physician as clinically contraindicated. R7's physician orders identified an order for olanzapine (antipsychotic medication) to be given twice daily related to depression and was started 1/19/23. R7 also received Sertraline given one time a day for depression with psychotic symptoms and was started 6/5/22. R7's Consultant Pharmacist's Medication Review, dated 6/6/25, identified Olanzapine 5 mg tablet take 1 tablet by mouth twice a day. This patient has been prescribed olanzapine since 1/20/22 and continued Sertraline 125 mg per day. Per Centers for Medicare and Medicaid Services (CMS) guidelines, all psychotropic medications should be considered for a trial dose reduction at least twice within the first year of use. If a dose decrease is contraindicated, rigorous risk/benefit documentation should be provided. A review of recent provider progress notes indicated R7 was followed by psychiatry for management of these medications, however, the most recent Psychiatry note on file in R7's electronic medical record (EMR) was 7/30/24, and while it stated to continue olanzapine 5 mg twice daily and Sertraline 125 mg daily, it does not include a thorough risk/benefit assessment for R7's psychotropic medications. Suggested course of action: if R7 was seen Psychiatry since the visit on 7/30/24, please obtain a copy of the progress note and file to the EMR, making sure that they addressed the ongoing need for the current psychotropic medications (why a dose reduction is clinically contraindicated). If R7 had not seen psychiatry since last July, consider scheduling a visit to have the provider assess the patient for a potential gradual dose reduction or if no longer followed by psychiatry, please have the primary evaluate R7 for a gradual dose reduction. Implementation time frame: nursing staff to address as soon as possible (ASAP) but no later than 30 days. R7's medical record lacked evidence a GDR had been attempted or identified a medical justification the resident was on the lowest effective dose within the past calendar year, or that the pharmacy recommendation	F0756		

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F0756 SS = D	Continued from page 20 had been followed up on. On 8/20/25 at 3:33 p.m., the director of nursing (DON) stated R7's last psychology visit was more than a year ago and had failed previous attempts for GDR's, however, the DON couldn't remember when GDR was attempted or if they were documented in R7's medical record. The DON stated she expected GDR's to be attempted or documented contraindications to be done yearly. On 8/20/25 at 4:21 p.m., a message was left for the consulting pharmacist requesting return call. The facility Psychotropic Medications policy reviewed 5/12/25, identified the consulting pharmacist would review resident medication records monthly for documentation/justification for the drug use and will recommend dosage reductions or modifications as appropriate. The facility policy Medication: Drug Regimen Review revised 12/2/24, identified a drug regimen review is performed for each resident at least once a month by a licensed pharmacist. This review must include a review of the residents' medical chart. The pharmacist will complete a written report noting any drug irregularities or issues of concern for each resident reviewed. The pharmacist will also complete the Medication Regimen Review Summary for QAPI Committee document. Both reports will be given to the director of nursing services upon completion of each monthly DRR. The reports must be shared with the attending physician and the location's medical director, and these reports must be acted upon. Should the consultant pharmacist detect a potential or actual problem that requires urgent action to protect the resident, he or she will promptly alert the direct care nurse for immediate action. If prescriber intervention is required, the consultant pharmacist will ensure proper communication is provided to the attending physician, nurse practitioner or physician's assistant to ensure resolution by midnight of the next business day. Drug irregularities will be reported to the medical director and attending physician by the director of nursing services or designee. The location must designate someone to ensure that these reports have been acted upon within 30 calendar days of the review and have been documented.	F0756		

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F0756 SS = D	Continued from page 21 Regarding psychopharmacological medications, the location will ensure that residents who have not used psychopharmacological medications and sedative/hypnotics are not given these unless this therapy is necessary to treat a specific condition, as diagnosed and documented in the medical record. In addition, those residents who do use these types of medications will receive gradual dose reductions or behavioral interventions, unless clinically contraindicated, in an effort to discontinue the drugs.	F0756		

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20000	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 8/18/25-8/20/25), a standard 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 Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		09/24/2025

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

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20000	Continued from page 1 The following complaints were reviewed: H56002322C (iQIES 1171529). No licensing orders were issued. 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 surveyor’s 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 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.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must	20830	Corrected	09/24/2025

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20830	Continued from page 2 be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to assess and analyze a resident fall with major injury to identify specific hazards and/or risks and to develop targeted interventions to reduce the potential for falls for 1 of 1 resident (R27) reviewed for falls. Findings include: R27's resident event form dated 8/8/25 at 4:45 p.m., identified on 8/8/25 R27 was observed peddling himself with his feet in the hallway, became tangled up in a computer table and fell out of his wheelchair. The wheelchair then fell on top of the resident. No immediate intervention put into place and unknown if there was an injury. R27's progress notes dated 8/11/25 at 4:50 p.m., identified R27 had a fall on 8/8/25 with a hip fracture and was currently in the hospital after hip nailing. Anti-roll backs would be applied to resident's wheelchair. However, the note failed to identify a description or cause of R27's fall. R27's falls tool report dated 8/15/25, identified R27 was at risk for falls related to an actual fall on 8/8/25, was taking 2 or more at risk medications, had moderately impaired cognition, reduced insight, delirium, poor memory and was impulsive. However, the tool failed to identify a description of or cause of R27's fall on 8/8/25. R27's care plan reviewed 8/18/25, identified R27 required staff assistance to transfer with a non-mechanical stand aide and did not ambulate. R27 had an actual fall with major injury and safety interventions included staff to remind resident not to bend over to pick up dropped items, use call light for assistance and keep personal items within reach. R27's medical record failed to identify a comprehensive assessment following the fall on 8/8/25, to include causal factors and/or root cause of R27's in an attempt to prevent further falls. R27's Medicare 5-Day Minimum Data Set (MDS) dated 8/20/25, identified R27 was readmitted to the facility on 8/14/25, after an acute hospital stay. R27 was	20830		

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20830	Continued from page 3 cognitively intact, required staff assistance with activities of daily living (ADL's), and had diagnoses including surgical repair of the right hip after a fall with major injury on 8/8/25. On 8/20/25 at 11:20 a.m., nursing assistant (NA)-E stated R27 had a fall recently when the resident reportedly fell in the lobby and fractured the right hip. Upon return from the hospital, R27 required more assistance with ADL's, couldn't stand on his own, and didn't call for help as much as previous. Staff used the manual sit-to-stand lift (a mobility aide designed to assist individuals in transitioning safely from sitting to standing) for all transfers. On 8/20/25 at 2:25 p.m., registered nurse (RN)-A stated R27 fell on 8/8/25, thought a note was entered in the EMR and remembered talking about the fall, although, upon request RN-A was unable to find documentation regarding the residents fall or discussions related to the fall. Further, RN-A stated R27's fall was not documented in the EMR. On 8/20/25 at 2:43 p.m., the DON stated the interdisciplinary team (IDT) met every Wednesday morning to discuss high risk incidents including resident falls. On 8/13/25 at 9:56 a.m., there was a note in the resident's chart identifying the IDT team met and discussed the residents fall, although the note failed to identify causal factors of the fall. The DON stated upon readmission, R27 had a fall tool was completed, although was uncertain what the assessment entailed or if the fall was assessed or analyzed to determine causal factors or a root cause. The DON stated interventions to prevent further falls included anti-roll backs on R27's wheelchair. The DON stated R27's fall was probably not documented in the medical record. The facility Fall Prevention and Management policy reviewed 4/8/25, included after stabilizing a resident from a fall with major injury, the nurse would complete a fall scene huddle worksheet, initiate an investigation into the fall, update the careplan, and document in Riskonnect. The completed fall scene huddle worksheet would be given to the fall committee chair or designee for review and follow-up. SUGGESTED METHOD OF CORRECTION: The DON or designee review and revise as needed the fall management policy to ensure all falls are comprehensibly assessed to identify interventions to try and prevent future falls, and then audit for compliance.	20830		

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20830	Continued from page 4 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	20830		
20905	Rehab - Positioning CFR(s): MN Rule 4658.0525 Subp. 4 Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning for 1 of 3 residents (R2) reviewed for pressure ulcers. Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning for 1 of 3 residents (R2) reviewed for pressure ulcers. Findings include: R2's quarterly Minimum Data Set dated 6/8/25, identified R2 had moderate cognitive impairment. Diagnoses included dementia, renal insufficiency and anemia. R2 was at risk of pressure injury/ulcer and required substantial/maximal assistance for bed mobility and was dependent on staff for transfers. R2's Braden Scale for Predicting Pressure Sore Risk dated 5/28/25, identified R2 was at high risk for pressure injury/ulcer. R2's care plan revised 5/29/24, included interventions to check and reposition R2 frequently during the day, 12:00 a.m. and 4:00 a.m. at night; turn from Side to Side: R2 required substantial/max assist of 1 staff member for turning side to side in bed with use of bilateral grab bars on bed. - During a continuous observation on 8/20/25 at 7:18 a.m., R2 was lying in bed. R2's head of bed (HOB) was approximately elevated to 30 degrees and R2's tv was on. R2's overbed table was in front of R2. R2 was rubbing her eyes and stated she was tired that morning. At 7:20 a.m., nursing assistant (NA)-E stepped	20905	Completed	09/24/2025

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20905	Continued from page 5 into R2's room and stated R2 wanted to eat breakfast in her room that morning. NA-E requested R2's breakfast order then raised R2's HOB so R2 was sitting upright. NA-E did not offer or reposition R2 before leaving the room. At 7:42 a.m., R2's breakfast tray was delivered and set up by kitchen staff. At 8:00 a.m., NA-C stepped into R2's doorway and asked R2 if she was "doing ok". R2 was eating her breakfast. NA-C did not offer or reposition R2. At 8:53 a.m., R2 continued to sit in the same position. R2's finished breakfast remained in front of her on the overbed table. At 9:46 a.m., NA-F entered R2's room and told R2 NA-F was going to "check her". NA-F removed R2's breakfast tray, performed incontinence cares and transferred R2 to her wheelchair with the full body mechanical lift and NA-E. - During an interview on 8/20/25 at 9:58 a.m., NA-F stated R2 needed to be turned and/or repositioned every two to three ours. During an interview on 8/20/25 at 10:02 a.m., NA-B and NA-C stated R2 needed to be turned and repositioned every two hours. NA-B stated the electronic point of care (POC) module directed the staff when residents were due and, once completed, the nursing assistants signed it off. NA-C stated she did R2's cares that morning before 7:00 a.m. and stopped into R2's room at 8:00 a.m. to reposition R2 but R2 was eating. However, NA-C did not offer to reposition R2 nor returned to R2's room after R2 was finished eating. NA-C stated someone should have. During an interview on 8/20/25 at 11:11 a.m., registered nurse (RN)-A stated R2 was at risk for pressure injury/ulcer and the nursing assistants should have offered to turn and reposition R2 was she was done eating breakfast. During an interview on 8/20/25 at 11:31 a.m., the director of nursing (DON) stated R2 typically had morning cares between 6:00 a.m. and 7:00 a.m. R2 liked to stay in bed for breakfast and the nursing would get R2 up into her wheelchair later in the morning. The DON stated staff should have offered to turn and reposition R2 approximately a half hour after eating. During an interview on 8/20/25 at 4:26 p.m., the administrator stated he expected staff to follow policy and procedure. The facility policy revised 4/6/25, identified Residents who are unable to reposition themselves independently, as indicated on the Sit-Stand-Walk Data Collection Tool UDA, should be repositioned as often as	20905		

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20905	Continued from page 6 directed by the care plan approaches. Developing an individualized repositioning schedule is required for those residents unable to position themselves and is based on nutrition, hydration, incontinence, diagnoses, mobility and observation of the resident's skin over a period of time. The Positioning Assessment and Evaluation UDA is a required tool that is used to determine an individualized repositioning plan. The positioning schedule should be communicated to the nursing assistants using the Kardex in PCC-POC. Any resident at risk will be placed on a pressure redistribution surface as determined appropriate. SUGGESTED METHOD OF CORRECTION: The DON or designee could reeducate staff on the importance or repositioning to prevent pressure ulcers, then perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	20905		
20910	Rehab - Incontinence CFR(s): MN Rule 4658.0525 Subp. 5 A.B Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a physician order for indwelling urinary catheter; and failed to ensure urinary catheter care was provided in a manner to prevent contamination and potential urinary tract infection (UTI) for 1 of 4 residents (R4) reviewed for urinary catheter. Findings include: R4's quarterly Minimum Data Set (MDS) dated 7/1/25, identified R4 had a severe cognitive impairment and had	20910	Completed	09/24/2025

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20910	Continued from page 7 diagnoses that included hematuria, neuromuscular bladder dysfunction (nerve damage that affects bladder control), reflux uropathy (the backward flow of urine from your bladder into your kidneys. Without treatment, the condition could lead to complications such as high blood pressure and chronic kidney disease.), type 2 diabetes, dementia and a methicillin resistant staphylococcus aureus (MRSA). R4 used an indwelling urinary catheter. R4's care plan revised 4/18/25, identified R4 had an indwelling catheter due to urinary retention and obstruction. Staff were instructed to:, Monitor/document for pain/discomfort due to catheter, Document intake and/or output., Monitor/document for pain/discomfort due to catheter, and Monitor/record/report to health care provider for signs/symptoms of urinary tract infection (UTI): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased R4's Interagency Handoff Report dated 7/8/25, identified R4 was hospitalized due to kidney stones and had ureter stents placed. R4's indwelling catheter was replaced while hospitalized on 7/1/25 with a 24 French (FR) foley catheter with a 60 milliliter (ml) balloon. The report failed to identify an order for continued urinary catheter use. R4's Order Summary report dated 8/21/25, identified maintain 20 FR coude catheter (a urinary catheter with a curved tip) with 30 ml balloon. Change every 14 days and as needed for obstruction at bedtime every 2 weeks related to urinary retention and obstruction was discontinued on 7/8/25. R4's nursing progress note dated 7/22/25 at 3:11 p.m., identified R4 had a follow-up Urology appointment on 7/21/25 and R4 was scheduled for further imaging of his kidneys and a follow-up Urology appointment with the provider who performed R4's procedure. The note failed to identify an order was received for continued urinary catheter use. R4's nursing progress note dated 8/3/25 at 7:52 a.m., identified R4's indwelling foley catheter was replaced with a 20 FR foley catheter with a 5 ml and urinary catheter bag falling apart. R4's prior catheter was intact but had a blood clot on the tip blocking urine flow. The note failed to identify if a provider was contacted to obtain an order for replacement. During an observation on 8/18/25 at 6:44 p.m., nursing	20910		

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20910	Continued from page 8 assistant (NA)-D assisted R4 with evening cares. NA-D wore gown, and gloves. When finished, NA-D hung R4's urinary catheter bag on the bedframe and lowered R4's bed to the floor. R4's urinary catheter bag port was not fastened to the holder and the bag rested on the floor. At 6:57 p.m., NA-D removed her soiled gloves, used hand sanitizer and put on new gloves. NA-D obtained a graduate from R4's closet and placed the graduate under R4's urinary catheter bag. NA-D drained approximately 500 cc of urinary from the bag then closed and cleaned the port with an alcohol wipe. NA-D poured the graduate into the toilet and set the graduate down. NA-D removed her gloves, washed her hands, then put on new gloves. NA-D then picked up the soiled graduate and placed it back into the closet. However, NA-D did not remove her soiled gloves. At 7:03 p.m., NA-D removed R4's teeth from his denture cap and placed them in R4's mouth. NA-D removed her soiled gloves/gown and used hand sanitizer before leaving the room. However, R4's urinary catheter bag remained on the floor.During an interview on 8/18/25 at 7:09 p.m., NA-D stated she did take off her gloves and wash her hands before putting away the graduate, but did not change her gloves before assisting R4 with his dentures because she thought the outside of the graduate was clean. Also, NA-D stated she left the urinary catheter bag touching the floor and R4 needed his bed lowered for safety. NA-D stated the urinary catheter bag should not lie on the floor because the floor was dirty, and it could lead to R4 getting an infection. During an interview on 8/20/25 at 11:12 a.m., registered nurse (RN)-A stated R4 had an order for his catheter before R4 was hospitalized but did not have a current order. RN-A stated he did see the note where R4's catheter was changed, and an order should have been obtained prior to changing. Also, when R4 returned from the hospital, the admitting nurse should have contacted R4's provider for further direction. Further a resident's catheter bag should never rest on the floor. The catheter bag should either be clipped higher or put in a cloth bag for basic hygiene and to keep the floor and catheter bag sanitary. Staff were expected to remove soiled gloves and wash hands prior to doing oral cares. During an interview on 8/20/25 at 1:19 p.m., the director of nursing (DON) stated the facility had a new policy to not flush or change a catheter unless there was a problem. R4 used to have weekly catheter changes and as needed. R4 returned to the facility with a 24 FR coude catheter and there was no order for weekly catheter changes, however, the DON was unaware R4 did not have an order for changes as needed. The staff	20910		

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20910	Continued from page 9 should have ensured there was an order before changing the catheter on 8/3/25. The DON had worked the night shift on 8/3/25 and the day nurse said she could change R4's catheter and the DON went home. The DON stated she did not verify R4's orders. Further, a barrier should have been placed under R4's urinary catheter bag or the urinary catheter bag placed into a cloth bag to prevent infection. The nursing assistants are trained to removed soiled gloves and wash their hands prior to doing oral cares. During a telephone interview on 8/20/25 at 3:32 p.m., the urologist stated he had only evaluated R4 the one time postoperatively. The urologist didn't have enough data from R4's hospital stay to be able to fully care for R4. Because of that, he referred R4 back to urologist who performed R4's procedure and ordered a follow up CT to ensure they had all the possible information for that appointment. For the urinary catheter, the urologist stated he could not determine why R4 had a 24 FR coude catheter with a 60 ml balloon was placed after R4's procedure. Because of that, he would expect staff to contact the discharging physician to obtain further direction and to follow orders as given. During an interview on 8/20/25 at 4:26 p.m., the administrator stated he expected staff to follow facility policy and procedure The facility policy Catheter Care: Insertion and Removal, Drainage Bags, Irrigation, Specimen revised 4/6/25, identified the following: Catheters will be inserted only with a physician's order and will include the type of catheter, size and balloon capacity for indwelling catheter. Catheter tubing should never be allowed to touch the floor. Non-obstructed "downhill" flow is always maintained. PROCEDURE Emptying Catheter Drainage Bag Equipment 1. Perform beginning five and apply gloves. 2. If splashing or spraying is anticipated use personal protected equipment (PPE). 3. When emptying the catheter bag, place a fluid-impermeable pad beneath the measuring container and avoid placing the container on the floor. 4. Open drainage port and allow urine to drain into measuring container placed underneath. Do not allow tip of tubing to touch sides of the measuring container or any surface.	20910		

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20910	Continued from page 10 5. When done, clean drainage port tip with alcohol wipe and replace in the holder. 6. Make sure the drainage bag and tubing are appropriately placed. 7. In rehabilitation/skilled care, if resident is on Intake and Output measure urine volume and record in PCC-POC/EMR. 8. Discard urine in toilet. 9. Wash and dry measuring container according to location procedure. Do not store the measuring container on the floor. 10. Perform ending five. 11. Note amount and character of urine. Report any significant observations to licensed nurse (blood, mucous, low urine output). SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff on obtaining orders for catheters prior to completing changes, educate staff on proper catheter care to prevent cross contamination, then audit for compliance TIME PERIOD FOR CORRECTION: Twenty One (21) days.	20910		
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	21426	Completed	09/24/2025

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21426	Continued from page 11 Based on interview and document review, the facility failed to ensure health care workers received a tuberculosis (TB) screening for 1 of 5 employees (nursing assistant (NA)-A) reviewed for TB screening. This had the potential to affect all 23 residents residing in the facility. Findings include: Personnel records identified NA-A was hired on 5/8/25 and had a QuantiFERON lab (a blood test for TB) done on 1/16/25. However, NA-A's personnel record lacked a TB screening. During an interview on 8/19/25 at 2:20 p.m., the director of nursing (DON) stated NA-A did not have a baseline TB screening done when she was hired. NA-A had already had a QuantiFERON lab test done 1/16/25, that identified she was negative for TB and doing a baseline screening had "slipped my mind". A TB screening should have been done to identify if there had been any changes since the QuantiFERON lab test. The facility's Tuberculosis Control Plan and Screening for Employees policy dated 6/1/25, identified prior to or upon hire, all employees will be screened for TB Risk and for signs or symptoms of active TB disease. The TB screening should be documented and uploaded to the employee's medical file. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and update as needed the process for obtaining TB screening per CDC regulations, educate staff and then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21530	Drug Regimen Review CFR(s): MN Rule 4658.1310 A.B.C A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.	21530	Completed	09/24/2025

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21530	Continued from page 12 B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist recommendations were addressed and acted upon and documented in the medical record for 2 of 5 residents (R26, R7) reviewed for unnecessary medications. Findings include: R26's quarterly Minimum Data Set (MDS) dated 7/2/25, identified R26 had a moderate cognitive impairment and had diagnoses that included dementia. R26 used antidepressant medication daily. R26's Order Summary Report dated 8/21/25, identified Trazodone HCl oral tablet (an antidepressant primarily used to treat major depressive disorder. It works by increasing serotonin levels in the brain, which can help improve mood, appetite, and energy levels, as well as reduce anxiety and insomnia related to depression. Additionally, trazodone is sometimes prescribed as a sleep aide due to its sedative effects, and it is considered non-addictive.) give 25 milligrams (mg) at bedtime related to unspecified dementia, moderate, with other behavioral disturbance was started on 1/28/25. R26's Consultant Pharmacist's Medication Review dated 7/11/25, identified R26 was prescribed Trazodone 25 mg	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Blackduck	**172 SUMMIT AVENUE WEST , BLACKDUCK, Minnesota, 56630**

(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
21530	Continued from page 13 at bedtime since 1/28/25. Per CMS guidelines, all psychotropic medications should be considered for a trial dose reduction at least twice within the first year of use. If a dose decrease is contraindicated, rigorous risk/benefit documentation should be provided. A review of recent provider progress notes did not yield a thorough risk/benefit assessment for this patient's psychotropic medications. Suggested course of action: Please evaluate the above psychotropic medications and consider reducing either the trazodone dose on a trial basis or provide clear clinical documentation as to why a dose reduction is contraindicated at this time. However, the form failed to identify a response from R26's physician. R26's medical record failed to identify R26's provider was contacted regarding R26's Trazodone and/or pharmacist's recommendations. During an interview on 8/20/25 at 11:28, the director of nursing (DON) stated she believed she missed R26 had an appointment with his physician, or she would have requested R26's Trazodone be discontinued. The DON preferred as many medication requests were done during appointments as possible because faxed requests usually did not generate a response. During an interview on 8/20/25 at 3:44 p.m., the consultant pharmacist stated, in general, after a resident was taking Trazodone for 6 months, a gradual dose reduction (GDR) was recommended. During an interview on 8/20/25 at 4:26 p.m., the administrator stated he expected staff to follow facility policy and procedure. R7's quarterly MDS dated 7/1/25, identified R7 had moderate cognition. Diagnoses included obsessive-compulsive disorder (mixed obsessional thoughts and acts), dementia, anxiety, depression and psychotic disorder. R7 received antipsychotics on a routine basis, a gradual dose reduction (GDR) had not been attempted or had not been documented by a physician as clinically contraindicated. R7's physician orders identified an order for olanzapine (antipsychotic medication) to be given twice daily related to depression and was started 1/19/23. R7 also received Sertraline given one time a day for depression with psychotic symptoms and was started 6/5/22. R7's Consultant Pharmacist's Medication Review, dated 6/6/25, identified Olanzapine 5 mg tablet take 1 tablet	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Blackduck	**172 SUMMIT AVENUE WEST , BLACKDUCK, Minnesota, 56630**

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21530	Continued from page 14 by mouth twice a day. This patient has been prescribed olanzapine since 1/20/22 and continued Sertraline 125 mg per day. Per Centers for Medicare and Medicaid Services (CMS) guidelines, all psychotropic medications should be considered for a trial dose reduction at least twice within the first year of use. If a dose decrease is contraindicated, rigorous risk/benefit documentation should be provided. A review of recent provider progress notes indicated R7 was followed by psychiatry for management of these medications, however, the most recent Psychiatry note on file in R7's electronic medical record (EMR) was 7/30/24, and while it stated to continue olanzapine 5 mg twice daily and Sertraline 125 mg daily, it does not include a thorough risk/benefit assessment for R7's psychotropic medications. Suggested course of action: if R7 was seen Psychiatry since the visit on 7/30/24, please obtain a copy of the progress note and file to the EMR, making sure that they addressed the ongoing need for the current psychotropic medications (why a dose reduction is clinically contraindicated). If R7 had not seen psychiatry since last July, consider scheduling a visit to have the provider assess the patient for a potential gradual dose reduction or if no longer followed by psychiatry, please have the primary evaluate R7 for a gradual dose reduction. Implementation time frame: nursing staff to address as soon as possible (ASAP) but no later than 30 days. R7's medical record lacked evidence a GDR had been attempted or identified a medical justification the resident was on the lowest effective dose within the past calendar year, or that the pharmacy recommendation had been followed up on. On 8/20/25 at 3:33 p.m., the director of nursing (DON) stated R7's last psychology visit was more than a year ago and had failed previous attempts for GDR's, however, the DON couldn't remember when GDR was attempted or if they were documented in R7's medical record. The DON stated she expected GDR's to be attempted or documented contraindications to be done yearly. On 8/20/25 at 4:21 p.m., a message was left for the consulting pharmacist requesting return call. The facility Psychotropic Medications policy reviewed 5/12/25, identified the consulting pharmacist would review resident medication records monthly for documentation/justification for the drug use and will recommend dosage reductions or modifications as appropriate.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/20/2025**

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21530	Continued from page 15 The facility policy Medication: Drug Regimen Review revised 12/2/24, identified a drug regimen review is performed for each resident at least once a month by a licensed pharmacist. This review must include a review of the residents' medical chart.The pharmacist will complete a written report noting any drug irregularities or issues of concern for each resident reviewed. The pharmacist will also complete the Medication Regimen Review Summary for QAPI Committee document. Both reports will be given to the director of nursing services upon completion of each monthly DRR. The reports must be shared with the attending physician and the location's medical director, and these reports must be acted upon.Should the consultant pharmacist detect a potential or actual problem that requires urgent action to protect the resident, he or she will promptly alert the direct care nurse for immediate action. If prescriber intervention is required, the consultant pharmacist will ensure proper communication is provided to the attending physician, nurse practitioner or physician's assistant to ensure resolution by midnight of the next business day.Drug irregularities will be reported to the medical director and attending physician by the director of nursing services or designee. The location must designate someone to ensure that these reports have been acted upon within 30 calendar days of the review and have been documented.Regarding psychopharmacological medications, the location will ensure that residents who have not used psychopharmacological medications and sedative/hypnotics are not given these unless this therapy is necessary to treat a specific condition, as diagnosed and documented in the medical record. In addition, those residents who do use these types of medications will receive gradual dose reductions or behavioral interventions, unless clinically contraindicated, in an effort to discontinue the drugs.SUGGESTED METHOD OF CORRECTION: The DON or designee could review policies and procedures to ensure pharmacy recommendations are acted upon, then educate staff on the process and audit for compliance TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21530		
21535	Unnecessary Drug Usage; General CFR(s): MN Rule4658.1315 Subp.1 ABCD Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy;	21535	Completed	09/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/20/2025**

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21535	Continued from page 16 B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure there was a comprehensive assessment and monitoring for prescribing a psychotropic medication for sleep for 1 of 6 (R26); and failed to provide evidence a gradual dose reduction (GDR) or a clinical justification of a psychotropic medication was completed for 1 of 6 residents (R26, R7) reviewed for unnecessary medication and were taking psychotropic medications. Findings include: R26's quarterly Minimum Data Set (MDS) dated 7/2/25, identified R26 had a moderate cognitive impairment and had diagnoses that included dementia. R26 used antidepressant medication daily. R26's Order Summary Report dated 1/28/25, identified Trazodone HCl oral tablet (an antidepressant primarily used to treat major depressive disorder. It works by increasing serotonin levels in the brain, which can help improve mood, appetite, and energy levels, as well as reduce anxiety and insomnia related to depression. Additionally, trazodone is sometimes prescribed as a sleep aide due to its sedative effects, and it is considered non-addictive.) give 25 milligrams (mg) at bedtime related to unspecified dementia, moderate, with other behavioral disturbance with a start date of 1/28/25. R26's medication record failed to identify R26's sleep was assessed prior to starting Trazodone or after	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/20/2025**

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21535	Continued from page 17 starting the medication to ensure it was effective. R26's care plan revised 2/23/25, identified R26 was on antidepressant medication therapy related to depression. Staff were directed to: Monitor R26's condition based on clinical practice guidelines or clinical standards of practice related to the use of Trazodone, and Consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate. R26's nursing note(s) identified the following: 6/26/25 at 3:46 p.m., identified the Mood/Behavior Committee met and reviewed R26's behavior/mood monitoring: hallucinations/delusions. R26's care plan and interventions were reviewed and continued to be appropriate. R26 had been sleeping a lot more lately. The note failed to identify if R26's sleep was monitored for potential side effects. 7/2/25 at 4:55p.m, identified R26 had a diagnosis of Dementia with Psychotic Disturbances and Dementia with Behavioral disturbances. R26 was alert although not always orientated. At times, R26 had thoughts that he needed to go to Blackduck and that he was not here already. Other times, R26 was fine. PHQ-9 Scored a 03 compared to 00 on last one. R26 said he was tired all the time. R26 answered all questions for interviews. There were no incidents over quarter. Staff were monitoring hallucinations and/or delusions. R26 had 60 occurrences over the quarter. There was four days in the look back period where R26 was confused where he was and got verbally aggressive with staff on one and was hollering out unsure where he was at. All four days involved not knowing where he was. Per staff interview, intervention remained appropriated. IDT Team and Behavior Committee just met and R26's mood/behavior monitoring continued to be appropriate. The note failed to identify if R26 had a sleep assessment and/or if R26's sleep was monitored for potential side effects.R26's Consultant Pharmacist's Medication Review dated 7/11/25, identified R26 was prescribed Trazodone 25 mg at bedtime since 1/28/25. Per CMS guidelines, all psychotropic medications should be considered for a trial dose reduction at least twice within the first year of use. If a dose decrease is contraindicated, rigorous risk/benefit documentation should be provided. A review of recent provider progress notes did not yield a thorough risk/benefit assessment for this patient's psychotropic medications. Suggested course of action: Please evaluate the above psychotropic medications and consider reducing either the trazodone dose on a trial basis or provide clear clinical documentation as to why a dose reduction is contraindicated at this time. However, the form failed	21535		

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21535	Continued from page 18 to identify a response from R26's physician. R26's medical record failed to identify R26's provider was contacted regarding R26's Trazodone and/or pharmacist's recommendations. R26's care conference note dated 7/22/25 at 1:30 p.m., identified R26 was sleeping and could not wake up. Could not ask R26 or family questions. R26 did a lot of sleeping during the day. Going to talk to the doctor about if he still needs the trazodone. The note failed to identify any further action. During an observation on 8/18/25 at 3:20 p.m., R26 was lying in bed asleep. R26 was sleeping since survey entrance and did not wake when greeted. During an observation on 8/19/25 at 8:34 a.m., R26 was in his room sitting reclined with his feet up in his wheelchair. Blankets covered R26 to his chin. R26's eyes were closed and did not respond when greeted. During an observation on 8/19/25 at 3:42 p.m., R26 was lying in bed asleep on his right side. R26 did not respond when greeted. During an observation on 8/20/25 at 7:32 a.m., R26 was lying in bed with the head of the bed elevated. R26 was covered to his chin with blankets. R26 was asleep and looked up when greeted but laid his head back down and closed his eyes. During an interview on 8/20/25 at 8:50 a.m., nursing assistant (NA)-D stated R26's eyesight was poor. R26 used to make comments like the sun was out but R26 didn't even do that anymore. R26 was pretty set in his ways but R26 did sleep a lot. During an interview on 8/20/25 at 11:08 a.m., registered nurse (RN)-A stated R26 was "pretty much like that": pretty laid back, relaxed and slept a lot. RN-A stated he was surprised R26 was on Trazodone because R26 slept a lot, and Trazodone would make R26 even more tired. The only sleep assessment ever conducted for R26 was on 4/4/16. RN-A could not determine why R26 was started on Trazodone and, normally, there was documentation to show why a medication like that was started. When a resident was taking a medication like Trazodone a sleep assessment should be done at least annually if not more often. During an interview on 8/20/25 at 11:28, the director of nursing (DON) stated she believed she missed R26 had an appointment with his physician, or she would have	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/20/2025**

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21535	Continued from page 19 requested R26's Trazodone be discontinued. The DON preferred as many medication requests were done during appointments as possible because faxed requests usually did not generate a response. During an interview on 8/20/25 at 3:44 p.m., the consultant pharmacist stated, in general, after a resident was taking Trazodone for 6 months, a gradual dose reduction (GDR) was recommended. During an interview on 8/20/25 at 3:14 p.m., social services designee (SSD)-A stated she completed the annual and quarterly MDS for sections C, D, and F. If there was a Care Area Assessment (CAA) for activities, SSD-A completed that as well. If a resident was on a medication for sleep, SSD-A entered a sleep study as well. SSD-A looked at the diagnosis on the medication sheet and if it stated the medication was for sleep, that would indicate a sleep study was needed. For R26, the medication diagnosis was for hallucinations, and a sleep study was not done. SSD-A stated, for side effects, a sleep assessment was a nursing responsibility. During an interview on 8/20/25 at 3:40 p.m., the DON stated she believed SSD-A did a sleep study for all residents on Trazodone, whether prescribed for sleep or not, because it has a sedating effect. "We need to improve our communication." The DON stated a any drug that affected brain activities associated with mental processes and behavior could be considered a chemical restraint and it should be monitored appropriately, and our documentation should show the rationale for use. It should be a team approach and never one nurse requesting a medication like that. Staff should always try other interventions first. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and update as needed the process and policy for initiating and monitoring psychotropics along with obtaining a GDR or justification for continued use, educate staff on the requirements and then audit to ensure continued compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245600	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Blackduck	172 SUMMIT AVENUE WEST , BLACKDUCK, Minnesota, 56630

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/19/2025. At the time of this survey, Good Samaritan, Blackduck 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. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		09/30/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245600	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/19/2025

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K0000	Continued from page 1 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 Blackduck is a 1-story building built at three different times. The first and major portion of the building was built in 1970, is 1-story with a basement and was determined to be Type I(332) construction. In 1996 a dining room/ PT addition was constructed to the north of the original building. This addition is 1-story, with a basement and was determined to be type II (111) construction. In 2009 a connecting link and activities addition Type V (III) was constructed to the north of the dining room. It is separated with a 2-hour fire barrier, 1-story, no basement , The facility has a complete automatic fire sprinkler system with quick response heads. The facility has a fire alarm system which includes smoke detection throughout the corridor system and in all common areas. All resident rooms have battery operated smoke detectors The facility has a capacity of 30 beds and had a census of 23 at the time of the survey.	K0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245600	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/19/2025

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K0000	Continued from page 2 The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		
K0291 SS = E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: ased on observation the facility failed to maintain emergency lighting system per NFPA 101 (2012 edition), Life Safety Code sections 19.2.9.1 and 7.9.1.3. This deficient practice could have a patterned impact on the residents within the facility. Findings include: On 08/09/2025 at 1150am, it was revealed by observation that the facility failed to conduct the annual 90 minute required Emergency Lighting test. An interview with the Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery	K0291	K 291 A 90-minute required Emergency Lighting test will be completed to maintain the emergency lighting system. The requirement for annual 90-minute Emergency Lighting test will be scheduled in our TELS system. The Maintenance Mechanic or Designee will report to the QAPI Committee the results of this test. The QAPI Committee will determine if further auditing needs are necessary. The Maintenance Mechanic is responsible for compliance with this requirement. Completion Date: 9/30/2025	09/30/2025
K0324 SS = D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.	K0324	K 324 Alignment markings were installed to ensure appliances are returned to an approved design location after being moved for maintenance and cleaning. Audits to ensure alignment markings are in place and gas-fired stove and griddle are in approved design location will be completed. The Maintenance Mechanic or Designee will complete monthly audits for three months to ensure alignment markings are in place and gas-fired stove and griddle are in approved design location. Results of these audits will be brought to the QAPI Committee for review and recommendations of further auditing needs. The Maintenance Mechanic is responsible for compliance with this requirement. Completion Date: 9/30/2025	09/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245600	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Blackduck	172 SUMMIT AVENUE WEST , BLACKDUCK, Minnesota, 56630

(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
K0324 SS = D	Continued from page 3 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to install the kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2*, 9.2.5, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. These deficient findings could an isolated impact on the residents within the facility. The findings include: On 08/19/2025 at 1148am, it was revealed that the wheeled, gas-fired stove and griddle located on the cooking line in the kitchen was not provided with an approved method of attachment and/or an alignment mark to ensure the appliances was returned to an approved design location after it had been moved for maintenance and cleaning. Both the attachment device and alignment mark are required for each gas operated and deep fat fryer cooking device. An interview with the Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery	K0324		
K0363 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	K0363	K 363 East wing storage closet/room door has been adjusted and is closing and latching when tested. East Wing dirty utility room door closer has been repaired. An audit will be completed of all corridor doors to ensure they are in good repair and close and latch appropriately. The Maintenance Mechanic or Designee will complete monthly audits for three months to ensure corridor doors are in good repair and close and latch. Results of these audits will be brought to the QAPI Committee for review and recommendations of further auditing needs. The Maintenance Mechanic is responsible for compliance	09/30/2025

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K0363 SS = D	Continued from page 4 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 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 STANDARD 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 an isolated impact on the residents within the facility. Findings include: On 08/19/2025 at 1127am, it was revealed by observation that East Wing storage closet/room did not latch when tested. On 08/19/2025 at 1129am, it was revealed by observation that East Wing dirty utility room door closer was in need of repair and/or replacement. An interview with the Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery	K0363	Continued from page 4 with this requirement. Completion Date: 9/30/2025	
K0712 SS = F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions.	K0712	K 712 A third shift fire drill was completed on 8/28/2025. Fire drills are scheduled in our TELS system to ensure they are completed at expected and unexpected times under varying conditions, at least quarterly on each shift.	09/30/2025

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K0712 SS = F	Continued from page 5 Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/19/2025 at 1100am, it was revealed by a review of available documentation that the facility missed the first quarter, third shift drill. An interview with the Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery.	K0712	Continued from page 5 The Maintenance Mechanic or Designee will complete monthly audits for three months to ensure fire drills are completed at expected and unexpected times under varying conditions, at least quarterly on each shift. Results of these audits will be brought to the QAPI Committee for review and recommendations of further auditing needs. The Maintenance Mechanic is responsible for compliance with this requirement. Completion Date: 9/30/2025	
K0914 SS = F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.	K0914	K 0914 Documentation was located showing repairs were finished by contractor on 5/5/2025 following annual receptacle inspection. Documentation showing repairs made following future receptacle inspections will be stored with the documentation of receptacle inspection. The Maintenance Mechanic will audit to ensure proper documentation of completion of repairs following annual receptacle inspection is located with the annual receptacle inspection. Results of these audits will be brought to the QAPI Committee for review and recommendations of further auditing needs. The Maintenance Mechanic is responsible for compliance with this requirement. Completion Date: 9/30/2025	09/30/2025

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K0914 SS = F	Continued from page 6 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/19/2025 at 1115am, it was revealed by review of available documentation the required annual receptacle inspection documentation was not able to show finished repairs to identified electrical issues at the time of the survey. An interview with the Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery	K0914		
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by:	K0920	K 920 Refrigerator plug in was removed from power-strip in the Director of Nursing office on day of survey. A building walk-through will be completed to ensure there are no other power-strips, multi-plug adapters and/or extension cords being used for appliances. The maintenance mechanic or Designee will complete monthly audits for three months to ensure no power-strips, multi-plug adapters and/or extension cords being used for appliances. Results of these audits will be brought to the QAPI Committee for review and recommendations of further auditing needs. The Maintenance Mechanic is responsible for compliance with this requirement. Completion Date 9/30/2025 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	09/30/2025

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K0920 SS = D Bldg. 01	Continued from page 7 Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/19/2025 at 1136am, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; 1) Power-strip in the Director of Nursing office An interview with the Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery	K0920	Continued from page 7 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.	