

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered May 9, 2023

Administrator Good Samaritan Society - Albert Lea 75507 240th Street Albert Lea, MN 56007

RE: CCN: 245441

Cycle Start Date: February 9, 2023

Dear Administrator:

On April 3, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 9, 2023

Administrator Good Samaritan Society - Albert Lea 75507 240th Street Albert Lea, MN 56007

Re: Reinspection Results

Event ID: NOL212

Dear Administrator:

On April 3, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 9, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 6, 2023

Administrator Good Samaritan Society - Albert Lea 75507 240th Street Albert Lea, MN 56007

RE: CCN: 245441

Cycle Start Date: February 9, 2023

Dear Administrator:

On February 9, 2023, 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.

Good Samaritan Society - Albert Lea March 6, 2023 Page 2

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

Good Samaritan Society - Albert Lea March 6, 2023 Page 3

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 May 9, 2023 (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 August 9, 2023 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Good Samaritan Society - Albert Lea March 6, 2023 Page 4

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor — Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145

Cell: (507) 361-6204

Email: william.abderhalden@state.mn.us

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us

PRINTED: 03/29/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONS	TRUCTION		(X3) DATE SURVEY COMPLETED
		245441	B. WING				02/09/2023	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY			75507 24	ADDRESS, CITO		<u> </u>	02/03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	•	(EACH CORF	R'S PLAN OF CORRE RECTIVE ACTION SH RENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00				
	compliance with Appreparedness Req facilities, §483.73(b) standard recertification of the facility's plan of the facility p	2/9/23, a survey for pendix Z, Emergency uirements for Long Term Care o)(6) was conducted during a stion survey. The facility was constituted in the survey of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567						
E 041 SS=F	Upon receipt of an onsite revisit of you validate substantial regulation has been Hospital CAH and I	acceptable electronic POC, an ir facility may be conducted to compliance with the attained LTC Emergency Power	ΕO	41				3/24/23
	(e) Emergency and hospital must imple power systems base forth in paragraph (policies and process)	on for Participation: I standby power systems. The ement emergency and standby sed on the emergency plan set (a) of this section and in the dures plan set forth in (ii) of this section.						
	LTC facility CAH a emergency and sta	25(e), §485.542(e) standby power systems. The nd REH] must implement ndby power systems based on n set forth in paragraph (a) of						
A D O D A T O D		3.73(e)(1), §485.542(e)(1),						(VC) DATE
-ADOKATOK	I DIKECTOR S OK PROVIL	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TIT	LC		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

03/16/2023

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245441	B. WING		02	C /09/2023
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP (75507 240TH STREET ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
E 041	must be located in requirements found Code (NFPA 99 and Amendments TIA 1 12-5, and TIA 12-6) and Tentative Interi 12-2, TIA 12-3, and when a new structus structure or building 482.15(e)(2), §483. §485.542(e)(2) Emergency genera [hospital, CAH and the emergency powand [maintenance] Health Care Facilitis Safety Code. 482.15(e)(3), §483. (3),§485.542(e)(2) Emergency genera LTC facilities] that into power emergency for how it will keep operational during the evacuates. *[For hospitals at §485.542(§485.625(g):] The standards inconsection are approved reference by the Diffederal Register in Federal Regi	tor location. The generator accordance with the location I in the Health Care Facilities of Tentative Interim 2-2, TIA 12-3, TIA 12-4, TIA 1, Life Safety Code (NFPA 101 m Amendments TIA 12-1, TIA 1 TIA 12-4), and NFPA 110, are is built or when an existing g is renovated. 73(e)(2), §485.625(e)(2), tor inspection and testing. The LTC facility] must implement ver system inspection, testing, requirements found in the es Code, NFPA 110, and Life 73(e)(3), §485.625(e) tor fuel. [Hospitals, CAHs and maintain an onsite fuel source by generators must have a plan emergency power systems the emergency, unless it	E O	41		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245441	B. WING		1	C 09/2023	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE	
E 041	inspect a copy at the Center, 7500 Seculor at the National Aladministration (NA availability of this magnetic properties of the Color o	ources listed below. You may be CMS Information Resource rity Boulevard, Baltimore, MD archives and Records RA). For information on the naterial at NARA, call to to: s.gov/federal_register/code_of is/ibr_locations.html. his edition of the Code are erence, CMS will publish a ederal Register to announce otection Association, 1 www.nfpa.org, Care Facilities Code, 2012 ust 11, 2011. In amendment (TIA) 12-2 to ugust 11, 2011. PA 99, issued August 9, 2012. PA 99, issued March 7, 2013. PA 99, issued March 7, 2013. PA 99, issued March 3, 2014.		41			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	` '	E SURVEY PLETED
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E 041	by: Based on a review and staff interview, on-site emergency 99 (2012 edition), has ection 6.4.1.1.6.1, (2010 edition ould have residents within the Findings include: On 02/09/2023 betwit was revealed by a documentation, that presented to confirm 36 months - 4 hour emergency general. An interview with the	of available documentation the facility failed to test the generator system per NFPA lealth Care Facilities Code, 6.4.4.1, 6.4.4.2 and NFPA 110.9, 8.4.9.2. This deficient re a widespread impact on the	E 04	Preparation and execution response and plan of corre constitute an admission or the provider of the truth of talleged or conclusions set is statement of deficiencies. It correction is prepared and/solely because it is required provisions of federal and state purposes of any allegat center is not in substantial with federal requirements of this response and plan of constitutes the center is all compliance in accordance of 7305 of the State Operation O04- Hospital CAH and LTC Power: 1. The Environmental Service and/or designee will schedul month 4 hour load bank test required for Type I generated on 3/7/23. 2. The 36 month 4 hour load be completed on 3/24/23. Assurance of On-going Conformation in Conformatio	ction does not agreement by the facts forth in the The plan of for executed d by the tate law. For tion that the compliance of participation, correction legation of with section in Manual. C Emergency ices Director ule the 36 st normally ors. Scheduled ad bank test will impliance: program will impliance: program will impleted: 3/7/23 maintenance I 36 month 4 onth prior to the to follow up ling the test to	

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E 041			E 04	System regulations. 3. This test will also be added to vendor's automatic scheduling s. 4. This will be audited weekly x a monthly x 3 to ensure compliant Results will be brought to the quassurance and performance confor review and further recommends.	ystem. 4 and e. ality nmittee		
F 000	recertification surve facility. A complaint conducted. Your factompliance with the Subpart B, Require Facilities. The following complete ficiency issued; H54418291C (MN8 H54418290C (MN8 H54418290C (MN8 H5441070C (MN8 H5441070C (MN8 H5441070C)) at the facility's plan of as your allegation of Departments accepted in ePOC, year the bottom of the form. Your electron be used as verificated.	2/9/23, a standard by was conducted at your investigation was also cility was found to be NOT in a requirements of 42 CFR 483, ments for Long Term Care claints were reviewed with no says and the says are received by the compliance upon the stance. Because you are rour signature is not required a first page of the CMS-2567 ic submission of the POC will the says are received by the compliance. cacceptable electronic POC, and a facility may be conducted to antial compliance with the					
F 684	Quality of Care		F 68	34		3/22/23	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	` '	E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	Continued From particles of CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatments facility residents. Be assessment of a restrict that residents received accordance with propractice, the compressive plan, and the residents REQUIREMENT by: Based on observative review, the facility frassess and monitor (R128) reviewed for conditions. Findings include: R128 was admitted Diagnosis listed on 1/26/23, located in Parkinson's disease nervous system that weakness, chronic kidneys fail to filter	care fundamental principle that ient and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered residents' choices. NT is not met as evidenced tion, interview and document ailed to comprehensively r bruises for 1 of 1 resident r non-pressure related skin to the facility on 1/26/23. the Diagnosis Sheet dated the medical record included: e, (disorder of the central at affects movement), kidney disease (when the waste and excess fluid from	F 6	F684: Plan of Correction: R128 has discharged from the fac Nursing management will review a current residents to ensure that all are documented. Further, nursing management will ensure the bruise listed on the Weekly Skin Observa tracking tool to ensure the bruises monitored weekly by licensed nurs staff. Nursing management will re care plans of all residents to ensur include potential for skin concerns applicable. Nursing staff will be educated on the process of thoroughly documented	bruises es are ation are ing view e the when he	
	lumbar vertebra (sr vertebrae). Observation and infa.m. R126 noted to bruises on the tops ranged in sizes from diameter. R126 ind	pression fracture of the nall breaks or fractures in the terview on 2/7/23, at 10:29 have several dark bluish of both hands. The bruises in 1/4 inch to 1 inch in icated he was not sure how he dinner.		bruises at the time of admission, in a description and measurements. Education will include adding bruis the Weekly Skin Observation track at the time of admission and when bruises are noted throughout a resistay. Education will be provided to via a meeting to occur on 3/16/23. Random audits to ensure compliant be conducted by nursing manager all residents in the facility who have	es to king tool new sident so staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245441	B. WING _			C 09/2023	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP 75507 240TH STREET ALBERT LEA, MN 56007	•		
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F 684	assessment dated having a brief interscore of "15" indicated indicated R126 required assistance with act. Review of the admit 1/26/23, identified bright and left hands (from IV) and a brut lower left leg. The findescription or size. R126's skin assessidentify or address lower left leg, that be R126's current care R126 requires assist resident participation R126 as having pointegrity. Intervention skin and complete the licensed nurse, at risk for bruising the admission skin. Review of the current looks are sident participation of the current looks. Also have the licensed nurse, at risk for bruising the admission skin. Review of the current looks are sident participation and in a.m. R126 noted to bruises on the tops ranged in sizes from diameter. R126 indicates.	Minimum Data Set (MDS) 1/30/23, identified R126 as view for mental status (BIMS) ating intact cognition. The MDS uired extensive staff ivities of daily living (ADL's). It data collection tool dated bruises on the back of R126's and a bruise on the left wrist is along the shin bone of the cool did not include a first of the bruises. In the bruises of the hands or the hand been identified on 1/26/23. It plan dated 1/27/23, indicated stance with ADL's, with on. The care plan identified tential for impairment to skin ons included; avoid scratching weekly skin observations by the care plan did not identify or current bruises identified on assessment. In the physicians orders dated aspirin 81 milligrams (mg) daily. It the tryiew on 2/7/23, at 10:29 or have several dark bluish of both hands. The bruises in 1/4 inch to 1 inch in licated he was not sure how he did unsure if they were	F 68	bruises. Audits will be con x 4 and monthly x 3. Audit brought to the Quality Assi Performance Improvemen review.	t results will be urance		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	l \	E SURVEY IPLETED
		245441	B. WING	j	02/	C / 09/2023
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		DULD BE	(X5) COMPLETION DATE
F 684	(NA)-A indicated Ratops of both hands NA-A indicated she darker in color and NA-A indicated she observations, becarnursing staff monitor and the indicated she observations, becarnursing (DON) confirmed (DON) confirmed indicated trained on the important and included the indicated she bruises were healing skin checks and skin checks a	at 1:00 p.m. nursing assistant 126 has had the bruises on the and shin since admission. thought the bruises looked thought they were worsening. had not reported her use she though the licensed or residents skin weekly. at 2:00 p.m. the director of firmed staff had not been bruises when identified. The sed all nursing staff had been ortance of monitoring skin		684		
	changes. Findings s skin observation to	nonitored weekly and with any should be documented on the ol and the residents care plan. Prevent/Heal Pressure Ulcer 1)(i)(ii)	F 6	686		3/22/23

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	COM	E SURVEY PLETED
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F 686	resident, the facility (i) A resident receive professional stands pressure ulcers and ulcers unless the indemonstrates that (ii) A resident with professional stands promote healing, promote hea	sure ulcers. orehensive assessment of a must ensure thates care, consistent with ards of practice, to prevent didoes not develop pressure adividual's clinical condition they were unavoidable; and oressure ulcers receives and ards of practice, to revent infection and prevent veloping. NT is not met as evidenced Intreview, observation, and olicy review, and review of elines, the facility failed to ment was completed for the use olaced on a pressure reducing to follow manufacturer se of a "Panacea Original re reducing)" for 1 of 3 miewed for pressure ulcers, potential for R10, who was at ment of pressure ulcers, to a ulcer (area of skin breakdown messure). In addition, the prehensively assess and titions to prevent worsening and itional pressure ulcers (PU)'s r 1 of 3 residents (R124)	F 6	F686: Plan of Correction Director of Nursing provided educ R10 and her daughter regarding the increased risk of pressure ulcer development related to using a formattress topper on 2/9/23. Daughter resident have chosen to keep foar mattress topper. R10 scare plan been updated to include assisting with repositioning every 2 hours a resident has not done so individual Nursing management reviewed al residents in facility and ensured the documentation of education provide those residents that do not have the facility issued pressure reducing mor additional padding on their padding extra padding on their mattressed extra padding on their mattressed risk of development of pulcers related to this choice. Care	he am am an has a has resident ally. I here was ded to he hattress he ess or as will be oressure	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	l` '	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP CO 75507 240TH STREET ALBERT LEA, MN 56007	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 686	the comprehensive facility must ensure the facility without provided pressure understand the facility without provided pressure understand the mattress should be or components	26/22, indicated "Based on a assessment of a resident, the e thatA resident who enters pressure ulcers does not alcers unless the individual's emonstrates that they were ment provided by the facility fam MattressOwner's "Never alter this product in of component of a Panacea e used with non-Panacea parts of the facility on 09/04/19, generalized muscle with the facility on 09/04/19, generalized muscle of decreased mobility and the intervention was to pressure reducing mattress. MR "Braden Scale for the sesure ulcers. A score of under was at risk for the development of a resident part of the development was at risk for the development."	F 6	will be updated to include a repositioning schedule per the individual needs. Nursing staff will be educated importance of educating resincreased risk of pressure unot using the facility spress mattress. Education will occurre to comeeting to occur on 3/16/23 R124 has discharged from the All residents at risk for pressiver eviewed to ensure the appropriate care planned interventions of the healing of currefulcers and to prevent skin be from occurring. Nursing staff will be educated care planned interventions for prevention and treatment of ulcers are in place and the intervention occurring and the intervention of ulcers are in place and the intervention and treatment of ulcers are in place and the intervention occurring. Random audits to ensure considered by nursing many weekly x 4 and monthly x 3. will be brought to the Quality Performance Improvement of Review.	he resident set on the idents on the locers when sure reducing our via a set there were reakdown and on ensuring or the pressure residents and it or residents 16/23. Impliance will enagement and to results a Audit results a Assurance	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	, , ,	TE SURVEY MPLETED
		245441	B. WING		02	C 2/09/2023
	PROVIDER OR SUPPLIER AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP C 75507 240TH STREET ALBERT LEA, MN 56007	<u> </u>	
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F 686	revealed R10 was impaired. The asserequired extensive mobility and transfered evelopment of preserved pointed to her mattrin pain due to the permission for the mattress. The cover cushion topper was reducing mattress. During an interview nursing assistant (I were both familiar stated they were as the resident's bed. During an interview director of nursing aware R10 had a femattress. DON N is for the development was made for docuversus benefits we and/or her family. A subsequent interest of the use of the development was made for docuversus benefits we and/or her family.	IS)" score of 11 out of 15 which moderately cognitively essment indicated R10 assistance of one staff for bed ers and was at risk for the essure ulcers. You on 02/07/23 at 9:00 a.m. R10 ress and stated her back was soor mattress. R10 gave surveyor to examine the ers were lifted and a foam a observed on a pressure. The resident stated her family shion in to attempt to make the		686		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245441	B. WING _		02	C /09/2023
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP C 75507 240TH STREET ALBERT LEA, MN 56007	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 686	stated she needed resident's family and No information was survey which address	to get in touch with the described review the clinical records. It is provided by the end of the essed the risk versus benefits the end of a foam cushion on R10's	F 68	36		
	diagnoses (identification order sheet) dated kidney disease (the excess fluid from the (change in average and unstageable proposed full thickness tissue or enon-viable tissue or enon-viable tissue a hard, dry and leath R124's admission assessment dated having a baseline in (BIMS) of "14" (cog	Ito the facility on 1/18/23, with ed on the active physician 2/8/23, including; chronic kidney fails to filter waste and he blood) altered mental status mental function) weakness ressure ulcer (ulcer that has e loss but is either covered by schar. Necrotic tissue is not eschar is dead tissue that is ery) of the right heel. minimum data set (MDS) 1/24/23, identified R124 as nterview for mental status initively intact). R124 required ivities of daily living (ADL's)				

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245441	B. WING _		02/09/2023		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 75507 240TH STREET ALBERT LEA, MN 56007	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	positioning and ware R124 as being at a unhealed unstage. Interventions included the PU care. Review of the admidated 1/18/23, identified pressure ulcer on measured 3.7 centwidth. The resident PU has a minimur drainage (thin pink tissue is pink in contact (absorbent dressin applied. Review of a wound 1/21/23, identified right heel. The PU (cm) length by 5.4 The PU has 30% greater the purpose of the purpose	sing, toileting, transfer, alking. The MDS identified risk for PU's and identified a able pressure ulcer. ded; a reduction mattress and nission data collection form ntified R124 as having a	F 68	6			
	(referred to as neother has a moderate and drainage and surrous Mepilex dressing a Review of a wound 1/27/23, identified right heel. R124 volume PU area. The PU length by 4.0 cm volumes.	rotic/fibrotic tissue). The PU mount of serosanguinous ounding tissue is pink in color. A					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		245441	B. WING		02/09/2023		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 75507 240TH STREET ALBERT LEA, MN 56007	<u> </u>		
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F 686	(white, yellow or brinfection) and skin breaking down of services of a wound 1/30/23, identified right heel. The PU cm width. The assection of the drainage on the PU cm width. The PU cm width and Services of a wound 2/5/23, identified Resible infection). dressing (absorbs with foam and Kerl Review of a wound 2/5/23, identified Resible infection). The PU cm width and 0.1 of the PU bed were mainimum amount of surrounding tissue the PU bed were mainimum a	nount of purulent drainage own fluid and can be a sign of is macerated (softening and kin) around the PU. I data collection tool dated R124 as having a PU on the measured 4.0 cm length by 3.1 essment did not include the ne PU bed. The PU had essing and the tissue J was pink. I date collection tool dated 124 as having a PU on the measured 4.0 cm length by 3.1 was described as having 100% PU had a moderate amount of ainage and the skin margins ith erythema (redness with Treatment of lodosorb wound fluids and kills bacteria) ix covering. I date collection tool dated 124 as having a PU on the measured 3.7 cm length by 5.4 m depth. The characteristics of ot described. The PU had a of serous drainage and noted to be macerated orb to wound base and cover		86			
	_	sition for a long period of time. t can make the PU worsen.					

1 ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		245441	B. WING		02/09/2023		
	PROVIDER OR SUPPLIER AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP C 75507 240TH STREET ALBERT LEA, MN 56007	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 686	pressure. Check winfection, redness and administer Oxysevere pain) 5 mg Review of a provid 1/24/23, by certificindicated R124 was R124's PU of the ridentified the PU to (Partial thickness Is shallow open ulcer without slough. Ma open/ ruptured blis granulation tissue. edges. Treatment (aids in debrideme damaged tissue arenvironment) with with kerlix. Change (PRN). Review aga (antibiotic) and connote further indicate wound nurse will be Review of a physic included lodosorb right heel, due to note ruptured to note further indicate wound nurse will be review of the care identified R124 as a series of	pillows under legs to reduce ound daily for signs of swelling and increased pain ycodone (used for moderate to bid (twice daily) for PU pain. er visit progress note dated of nurse practitioner (CNP)-A, as seen related to a change in ght heel. The progress notes of the heel as a stage 2 ulcer cass of dermis presenting as a with a red-pink wound bed, y also present as an intact or ter) with some eschar and Erythema around the PU orders to apply Medihoney and, of which is the removal of ad provides a moist healing foam dressing cover and wrap of dressing daily and as needed ain in 2 days. Start Doxycycline tinue offloading. The progress ed the NH (nursing home)	F 6	86			
	included; assess/redaily on the wound assess weekly with	and weakness. Interventions cord/monitor wound healing data form, facility RN to skin assessments, float heels cam boots and/or pillows.					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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F 686	every 2-3 hours an with the blue foam resident with socks sock aid or shoe he may be difficult for R124 has pain in the evaluate the effect given. Observation and in R124 was sitting it dependent to the fileg and foot was shad a gripper sock the floor. R124 state boot to her right for not wear during the usually has her tenget it on. R124 furthelevate her feet or during the day, rathin bed. R124 state the footrest herself. Observation on 2/7 treatment was don (DON). R124's right dressing was remote the footrest herself. Observation on 2/7 treatment was don (DON). R124's right dressing was remote the footrest herself. Observation on 2/7 treatment was don (DON). R124's right dressing was remote be tight and diffiresident complaining was covered with resident complaining was covered with resident satisfication. After staff assisted with shoe back on. President complaining skin. After staff assisted with shoe back on. President complaining skin. After staff assisted with shoe back on. President complaining skin. After staff assisted with shoe back on. President complaining skin. After staff assisted with shoe back on. President complaining skin. After staff assisted with shoe back on. President complaining skin.	to change positions at least d to not stand up or transfer boot on. Staff to assist the and shoes. R124 may use a corn to get her shoes on, but her due to her right heel PU. he right heel ulcer and staff to eveness of the pain medication terview on 2/7/23, at 9:30 a.m. In her recliner with her feet oor. The residents right lower ightly swollen. The right foot on. Both heels were resting on ted she had a PU on her heel. Cotive heel boot sitting next to ed she wears the protective of during the night, but does eday. R124 indicated she nis shoe on but needed help to her indicated she did not have her feet off the floor her just during the night when dit was too difficult to elevate	F 68	36			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	· /	(X3) DATE SURVEY COMPLETED	
		245441	B. WING		02/09/2023		
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP (75507 240TH STREET ALBERT LEA, MN 56007	<u> </u>		
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F 686	The shoe horn was pressure ulcer. Inte time, stated that sh for at least a week of pain when having and taken off. Observation on 2/9 treatment was done R124's tennis shoe removed from the reteth and complain done. There was a colored drainage of brownish color) R1 covered with necrocleansed the PU, for pain. The tissue macerated with per 1.0 inch diameter of above the PU on the this was a change in measured 3.4 cm I also indicated R124 prior to the dressing had a lot of pain with complained of increased to put on a complained	he heel to get the shoe on. Is pressed against part of the erview with the resident at this e had been wearing her shoes and she has been having a lot g her sock and shoes put on 1/23, at 9:00 a.m. R124's PU e by registered nurse (RN)-B. Is, sock and dressing was ight foot. R124 clenched her ed of pain when this was moderate amount of brownish in the dressing (Isosorb has a 124's PU was observed to be tict tissue. When RN-B R124 flinched and complained around the PU noted to be eling skin. There was also a discolored area in the skin her right heel. RN-B indicated in the tissue. The PU ength by 4.6 cm depth. RN-B received Oxycodone for pain g change at 5:30 a.m., but still the treatment. Because R124 eased pain when putting on sock and tennis shoe, R124 gripper sock at this time. The course of the survey on 23, R124 was observed to be er with both of her feet/heels on a wearing tennis shoes during r/23 through 2/9/23. When again on 2/8/23, at 2:00 p.m. and did not elevate her legs or the floor when up during the day.		86			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
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F 686	of the recliner up hand offer to assist. assist her with wear R124 indicated she would do anything could happen. Interview on 2/7/23 (NA)-A confirmed Findicated she the right heel, but wother than the nurse right heel. NA-A function the day with her recliner with he she was not aware day, but was awar boots at night when R124 wears tennis. Interview on 2/8/23 confirmed R124 spher recliner with he she was not aware day, but was awar boots at night when R124 wears tennis. Interview on 2/9/23 R124's PU on the recovering R124's enthe entire PU is confirmed R124 wears tennis. Interview on 2/9/23 R124's enthe entire PU is confirmed R124 wears tennis. Interview on 2/9/23 R124's enthe entire PU is confirmed R124 wears tennis. Interview on 2/9/23 R124's enthe entire PU is confirmed R124 wears tennis. Interview on 2/9/23 R124's enthe entire PU is confirmed R124 wears tennis. Interview on 2/9/23 R124's enthe entire PU is confirmed R124 wears tennis.	e could not get the foot pedals erself and staff do not come in R124 stated the staff did uring protective boots at night. It wanted to go home and to help the PU heal, so that to help the recliner most of et/heels touching the floor. It was aware of R124's PU on was unsure of any interventions to the ther verified R124 wears her ghout the day. If at 11:00 a.m., NA-B heads a lot of the day sitting in the ethat R124 wears protective in bed. NA-B further verified shoes throughout the day. If at 9:00 a.m. RN-B indicated high heel has not improved. 24 did not have necrotic tissue hitre PU on admission, but now wered with necrotic tissue. The ed it was difficult taking R124's and off due to causing on on the PU, that caused the resident. RN-B further 24's PU was identified to he provider was notified and a	F 6	86			

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP C 75507 240TH STREET ALBERT LEA, MN 56007	'		
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F 686	tennis shoes since aware of. PT-A ind R124's shoes being shoe horn, to assist off. PT-A indicated where the PU was indicated when R12 independently in he been a interdisplina Options and the cobeen discussed to well as safety of the indicated this had not been when encoural indicated since the independently (about to wear her tennis so RN-C indicated R124 ware even when encoural indicated since the independently (about to wear her tennis so RN-C indicated R124 difficult if she had to walking to the bath confirmed she did not family related to throughout the day RN-C verified no ot R124 related to foo pressure on the head to the later of the later	ated R124 has been wearing admission, that she was icated she had been aware of g tight and gave her a metal twith putting the shoe on and she was unaware of exactly located on the heel. PT-A 24 was given the ok to walk er room, there should have any discussion with nursing. Indition of the PU could have bromote healing of the PU as eresident with walking. PT-A not been done. If at 9:30 a.m. with RN-C and to wear tennis shoes, aging her not to. RN-C appy allowed R124 to walk that a week ago) R124 started shoes due to the risk of falling. 24 thought it would be too of put on her shoes on, when room and to meals. RN-C not review the risks with R124 wearing the tennis shoe and not elevating her legs. her options had been given for twear, that would promote less		586			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING		TIPLE CONSTRUCTION ING	CON	(X3) DATE SURVEY COMPLETED	
		245441	B. WING			C /09/2023	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP (75507 240TH STREET ALBERT LEA, MN 56007	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 686	pressure to the PU Facility policy titled Ulcer Prevention and 4/26/22, indicated to appropriately use pupressure redistributions residents at risk for interdisciplinary teal modifications that a plan of care. Interven	Skin Assessment Pressure of Documentation, dated he purpose of the policy is to revention techniques and ion surfaces on those PU. The policy indicated the m should determine any are necessary to the residents entions should focus on	F 6	586			
F 689	that may be impact interventions should residents goals. Ed the resident and/or not determine to be ulcer should show stwo to 4 weeks. Signification include decrease in and improvement in slough to granulation makes an informed interventions, then what the risk of the outcome should be and/or family. The edocumented.	I and psychosocial aspects ed. Treatments and d be consistent with the ucation should be provided to family. If a pressure ulcer is clinically unavoidable, the signs of improvement within as of improvement might size, decrease in exudate a tissue (from necrotic to on to epithelial) If a resident choice to refuse treatment or education of what a PU is, refusal is, and the potential provided to the resident education should be azards/Supervision/Devices	F 6	589		3/22/23	
	CFR(s): 483.25(d)(§483.25(d) Accident The facility must en §483.25(d)(1) The	1)(2) its.					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ′	(X3) DATE SURVEY COMPLETED	
		245441	B. WING _		02/09/2023		
	PROVIDER OR SUPPLIER AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007	<u> </u>	JOILULU	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APPROPRIES (PROSS-REFERENCE)	OULD BE	(X5) COMPLETION DATE	
F 689	Continued From pa	age 20	F 6	89			
	supervision and as accidents. This REQUIREMED by: Based on observative, the facility for review, the facility for reviewed for accidental for reviewed for accidental for the facility on the	ectronic medical record (EMR) ecord," located under the ted the resident was admitted /25/22, with a diagnosis of y swallowing). The provided by the facility tion Form," dated 08/26/22, of supervision while eating was tent provided by the facility rders," dated 08/26/22, ent could have "Distant Meals/PO [oral] Intakes." "Diet Notification Form," ech Therapist (ST) on 09/21/22, mendation for the resident to sight" supervision and be		F689: Plan of Correction: R45□s care plan was reviewed continues to eat meals in main room with distant line of sight st R45 was re-evaluated by speed on 2/16/23 and his care plan way with her recommendations. The care plans, dietician assess and speech therapy assessmer applicable) were reviewed for a to ensure all residents were eat location to provide the necessa supervision to meet their needs plans were updated if applicable level of supervision needed for was added to their dining tray cadditional reminder to staff. Nursing staff will be educated of importance of supervision for rewho are receiving altered diets risk for choking via a meeting to on 3/16/23. Random audits to ensure comp be conducted by nursing managements weekly x 4 and monthly x 3. Auwill be brought to the Quality As Performance Improvement Corrections.	dining upervision. th therapy as updated sments, its (when ll residents ing in a ry . All care e. The residents ards as an in the esidents and are at be held liance will gement idit results surance		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION DING	l \ /	(X3) DATE SURVEY COMPLETED	
		245441	B. WING		02/09/2023	
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F 689	Summary" written indicated a recommodicated a recommodining room when consuming not s/s [signs and syswallowing difficultion of swallowing difficultion of swallowing of syswallowing of syswallowing of syswallowing and syswallowing an observation of syswallowing an observation. During an observation observation observation. During an observation o	R45's "ST [speech at Progress & Discharge by the ST on 10/20/2022, mendation for the resident to ". We distant supervision and eat in for meals to ensure safety meal and monitor for increase ymptoms] of aspiration or other ies" MR titled significant change eet (MDS)" with an ence Date (ARD) of 11/14/22, ent had a "Brief Interview for IS)" score of five out of 15 swas severely cognitively essment indicated the resident on, such as oversight and of a meal. The Care Area of located under the red nutrition and directed the		589		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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F 689	R45 was at risk of props the resident's so she can keep a resident was curredid not go to the modern did not go to the unit manager (Not for for for for modern did not go to the unit manager (Not for	NA) H stated she was aware choking. NA H stated she is door open during mealtimes in eye on him. NA H stated the intly on contact precautions and ain dining room. You on 02/09/23 at 7:32 a.m., repically went to the main dining it was under contact in done. You on 02/09/23 at 10:11 a.m., in the main dining it was under contact in the main dining er on the 300 unit and it familiar with R45. NM D it typically ate in the main dining eats in his room due to being it in his room, during it was in his room, during it was outside of his room, during it was at 10:15 a.m., in a stated R45 eating in his rmittent "line of sight" of adequate. ST A stated her indations was for the resident room with direct "line of sight" as based upon her evaluation esident's discharge from skilled and without a new evaluation or ursing that the resident the resident alone in his room,		39			

1 ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245441	B. WING			02/09/2023		
NAME OF F	PROVIDER OR SUPPLIER				RESS, CITY, STATE, ZIP COD		02/03/2023	
				75507 240TH				
GOOD SAMARITAN SOCIETY - ALBERT LEA					EA, MN 56007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTIVE ACTION SH S-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 689	•		F 6	89				
	not done by staff.	tion precautions and this was						

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

F5441033

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - ALBERT LEA GOOD SAMARITAN

PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

			CENTER			
		245441	B. WING _		02/09/2023	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
00000		AL DEDT LEA		75507 240TH STREET		
GOOD S	AMARITAN SOCIETY	- ALBERT LEA		ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
K 000	INITIAL COMMENT	rs -	K 00	00		
	FIRE SAFETY					
	conducted by the M Public Safety, State 02/09/2023. At the SAMARITAN SOCII found not in complia participation in Med Subpart 483.70(a), 2012 edition of Nati Association (NFPA) Chapter 19 Existing edition of NFPA 99, THE FACILITY'S PO ALLEGATION OF CO DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CMS USED AS VERIFICA UPON RECEIPT OF ONSITE REVISIT OF CONDUCTED TO A SUBSTANTIAL CON REGULATIONS HA ACCORDANCE WI PLEASE RETURN CORRECTION FOR DEFICIENCIES (K-	MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION. THE PLAN OF R THE FIRE SAFETY TAGS) TO: IN THE E-POC PROCESS, A THE PLAN OF CORRECTION				
_ABORATOR\	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURF	TITLE	(X6) DATE	
Electron	ically Signed			itution may be evened from correcting providing	03/16/2023	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ALBERT LEA GOOD SAMARITAN CENTER			(X3) DATE SURVEY COMPLETED	
		245441	B. WING_		02/	09/2023
	PROVIDER OR SUPPLIER AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From particle Healthcare Fire Institute State Fire Marshal 445 Minnesota St., St. Paul, MN 55107 By email to: FM.HC.Inspections	pections Division Suite 145 I-5145, OR	K 0	00		
	DEFICIENCY MUSIFOLLOWING INFO 1. A detailed described taken or planned to a substantial street of the substantial street	oription of the corrective action correct the deficiency. easures that will be put in deficiency does not reoccur. e facility plans to monitor to ensure solutions are				
	5. The actual or pathe remedy. GOOD SAMARITA a 1 story building was a The original building was determined to construction. In 196 constructed and was (111) construction.	onstructed at 6 different times. g was constructed in 1965 and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ALBERT LEA GOOD SAMARITAN CENTER		(X3) DATE SURVEY COMPLETED			
		245441	B. WING			02/	09/2023
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ALBERT LEA				75507	T ADDRESS, CITY, STATE, ZIP CODE 240TH STREET RT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 211 SS=F	(111) construction. It constructed and wa (111) construction. Constructed and wa (111) construction. Constructed and wa (111) constructed and wa (111) construction. Because the original are of the same type existing buildings, the one building, Type I was a case open to the automatic sprinkler system with smoke spaces open to the automatic fire department at NOT MET as evide Means of Egress - CFR(s): NFPA 101 Means of Egress - CFR(s): NFPA 101 Means of Egress - CAISIES, passageway exit locations, and a with Chapter 7, and continuously maintal	In 1980 an addition was as determined to be of Type II In 1997 an addition was as determined to be of Type II In 1998 an addition was as determined to be of Type II In 1998 an addition was as determined to be of Type II In 1998 an addition was as determined to be of Type II In 1998 an addition was as determined to be of Type II In 1998 an addition was a for addition was a fire alarm detection in corridors and corridors that is monitored for a time of the survey. 42 CFR, Subpart 483.70(a) is not by: General General	K 2				3/16/23
	18.2.1, 19.2.1, 7.1.1 This REQUIREMEN by:			Pr	eparation and execution of this		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ALBERT LEA GOOD SAMARITAN CENTER			(X3) DATE SURVEY COMPLETED	
		245441	B. WING		02/0	9/2023	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG) BE	(X5) COMPLETION DATE	
	per NFPA 101 (201 sections 19.2.1, 7.1 deficient findings coon the residents with Findings include: On 02/09/2023 betwith was revealed by 6700 Wing exit paths snow and ice. An interview with the	ans of egress requirements 2 edition), Life Safety Code 1.6.4, and 7.1.10.1. These ould have a widespread impact		response and plan of correction do constitute an admission or agreem the provider of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plan correction is prepared and/or exect solely because it is required by the provisions of federal and state law the purposes of any allegation that center is not in substantial compliant with federal requirements of particities this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manu K211 Means of Egress — Paths of It is the policy of the facility to main paths of egress in accordance with requirements. Corrective action will include the form 1. All snow and ice were removed the 500, 600, 700 wing exit pathway 02/15/2023 2. All residents and staff have the potential to be affected by this prace.	ent by the the tof uted For the nce pation, of tion al. Egress tain NFPA Illowing: d from nys.		
				Snow removal of all sidewalks and of egress will be cleared of snow to hinder evacuation of residents in the of emergencies. Removal of snow sidewalks and means of egress with to be removed by maintenance directly designee after approximately 1 incommon snow accumulation. Snow shovels ice melt will be placed at each facility for staff to have quick access for content of egress doors. 3. Upon snow fall, both maintena	not ne event on all ll start ector or h of s and ity exit learing		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG 01 - ALBERT LEA GOOD SAMARITAN	COMPLETED	
		245441	B. WING _		02/09/2023	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ALBERT LEA				STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007		
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K 353	Sprinkler System - Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspected in a section available.	Maintenance and Testing Maintenance and Testing and standpipe systems are and maintained in accordance dard for the Inspection, ining of Water-based Fire . Records of system design, action and testing are aure location and readily system last checked	K 21	director and facility administrator we monitor the amount of snow fall and maintenance director will begin snow removal on all means of egress after approximately 1 inch of snow accumulation. If at any point the maintenance director is unavailable administrator or designee will complete the removal of snow to ensure safe egress for evacuations in the even emergency. 4. Compliance will be monitored facility administrator and QAPI comply performing audits on days of snow accumulation of 1 inch or greater the ensure snow was removed for safe egress. Audits will be completed by administrator or designee on days forecasted to have snow. Compliance will be met on or before 03/01/2023	d the ow eer e, the plete e t of an by the nmittee ow o e y the	

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		245441	B. WING		02/0	9/2023
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET		
	T			ALBERT LEA, MN 56007		
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K 353	Continued From pa	ige 5	K 3	53		
	any non-required of system. 9.7.5, 9.7.7, 9.7.8, a This REQUIREMENT by: Based on observation facility failed to main accordance with NR Safety Code, section edition) Standard for Maintenance of Wasystems, sections 13 (2010 edition), Sprinkler Systems, deficient findings on the residents with Findings include: 1. On 02/09/2023 b PM, it was revealed head located in the exhibited signs of be compared to the property of the pro	tion and staff interview, the ntain the sprinkler system in FPA 101 (2012 edition), Life ons 9.7.5, and NFPA 25 (2011 or the Inspection, Testing, and ater-Based Fire Protection 5.2.1.1.2, 5.2.2.2, and NFPA Standard for the Installation of section 8.5.6.1. These ould have a patterned impact thin the facility. Detween 1000 AM and 0300 d by observation, the sprinkler 100 Wing Janitor Closet, being painted. Detween 1000 AM and 0300 d by observation, in the office closet, that items were see proximity to the sprinkler		K353 NFPA Sprinkler Systems It is the policy of the facility to perf assure sprinkler systems are teste accordance with NFPA standards requirements. And accept this fac credible allocation of compliance a correct the citation K353 Corrective action will include MEA and changes used to prevent a recurrence: 1. Environmental Services and designees will schedule sprinkler replacement for the sprinkler head 100 wing Janitor Closet. Schedule Completed: 3/22/2023 2. Environmental Services and d will remove items to maintain 18" clearance from the sprinkler deflet the Physical Therapy Office Close completed by: 03/8/2023 3. Environmental Services and d will remove foreign debris from sp heads outside of Rooms 1201, 12 1207. To be completed by: 02/18/2 4. Preventative maintenance pro and instructions will be updated to Quarterly scheduled fire sprinkler inspections, maintenance and test Completed 03/01/2023 Assurance of On-Going Complian The Environmental Services Direct and/or designee will conduct quar	ed in and littles and SURES head lin the ed to be lesignee rinkler 03, and 2023 gram include systems ling: ce etor	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ALBERT LEA GOOD SAMARITAN CENTER (X3) DATE SURV COMPLETE				
		245441	B. WING			02/	09/2023
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	Continued From pay verified these deficit discovery. Portable Fire Exting	ent findings at the time of	K 3		inspections to ensure fire sprinkler systems meet this requirement and identified in our preventative mainted program. The facility safety committee will reand oversee documentation that should that the aforementioned inspections performed quarterly as required for period of 12 months. Beginning 03/08/2023. The facility administrator will monitor verify Quarterly fire sprinkler system not obstructed and inspected are completed and documented per as PM scheduling. Beginning 03/01/20	l as enance view nows s are a or and ns are signed	3/16/23
	Portable Fire Exting Portable fire extinguishers. 18.3.5.12, 19.3.5.12 This REQUIREMEN by: Based on a review and staff interview, inspect, and maintafire extinguishers in (2012 edition), Life 19.3.5.12, 9.7.4.1, a Standard for Portable 7.2.4.1, 7.2.4.3, and	juishers uishers are selected, installed, ntained in accordance with for Portable Fire 2, NFPA 10 NT is not met as evidenced of available documentation the facility failed to properly in documentation of portable accordance with NFPA 101 Safety Code, sections and NFPA 10 (2010 edition), ble Fire Extinguishers, section 17.3.1.1.1. This deficient a widespread impact on the			K355- Portable Fire Extinguishers It is the policy of the facility to main portable fire extinguishers in accord with NFPA standards and requirem Corrective action will include: 1. The Environmental Services Dire and/or designee will schedule annuinspection of portable fire extinguis Completed 3/1/23. 2. The Environmental Services Dire and/or designee will review current	dance ents. ector hers.	

	AND DIANIOE CORRECTIONI I DENTIFICATIONI NI IMPER:			(X3) DATE SURVEY COMPLETED			
		245441	B. WING			02/09/2023	;
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		7	TREET ADDRESS, CITY, STATE, ZIP CODE 5507 240TH STREET LBERT LEA, MN 56007		
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K 355	1. On 02/09/2023 between 1000 AM and 0300 PM, it was revealed during a review of available documentation that no annual inspection and maintenance records were available for review 2. On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by observation, the fire extinguisher located in the Elevator Room had not been inspected, monthly or annually, since 2020. 3. On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by observation, the fire extinguisher located in Wing 700 - Storage Room had no monthly dates recorded on the inspection tag An interview with the Maintenance Director verified this deficient finding at the time of		K	plans to include portable fire exting location in the elevator room and the Wing storage room for monthly/and inspections. Completed 2/20/23. Assurance of On-going Compliance. 1. Environmental Services Director designee as part of the monthly Firextinguisher inspections prevental maintenance program will verify the documentation is visible and access. Portable fire extinguishers will be audited weekly x 4 and monthly x and the ensure compliance with NFPA standard results will be brought to the Assurance and Performance Improvement Committee for review further recommendations.		e 700 ual e: and/or e/ce t sible. to dards. Quality	
K 372 SS=F	Subdivision of Build Construction 2012 EXISTING Smoke barriers shafire resistance ratin be permitted to terr Smoke dampers ar penetrations in fully an approved sprink smoke compartments barrier. 19.3.7.3, 8.6.7.1(1)	ling Spaces - Smoke Barrier all be constructed to a 1/2-hour g per 8.5. Smoke barriers shall ninate at an atrium wall. The not required in duct of ducted HVAC systems where her system is installed for ents adjacent to the smoke anical smoke control system		372		3/31/23	3

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ONG 01 - ALBERT LEA GOOD SAMARITAN	` '	DATE SURVEY COMPLETED	
		245441	B. WING		02/0	09/2023	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007			
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K 372	by: Based on a review and staff interview, inspect the facility s (2012 edition), Life 8.5.5.4.2, and NFP/Standard for Smoke Opening Protective deficient finding country on the residents with Findings include: On 02/09/2023 betwit was revealed during the last documenter inspection and testing 12/17/2018. An interview with the	of available documentation the facility failed to test, and moke dampers per NFPA 101 Safety Code, sections 8.5.5.2, A 105 (2010 edition), e Door Assemblies and Others, section 6.5.2. This ald have a widespread impact		K372: Subdivision of Building Spa Smoke Barriers/Smoke Damper T It is the policy of the facility to commaintain in reliable operating conditions and to ensure Alarm Systems and to ensure Alarm Systems are inspected, test maintained periodically. Corrective action will include: 1. Environmental Services Director designee will schedule smoke dar inspection and testing. Scheduled 2/15/23 2. Testing scheduled to be completed 3/31/23. Assurance of On-Going Compliant 1. To ensure system continues to NFPA requirements, the facility's preventative maintenance programupdated to include all of the requirements. This task was completed 3/7/23. 2. This program will flag the smok damper inspection one month pricinspection due date to ensure that inspection is scheduled with our ocontractor. 3. This inspection has also been a our contractor's automatic schedule system. 4. Audits will be performed by the Environmental Services Director of 4 and monthly x 3 to ensure compandit results will be brought to the Assurance and Performance	tinuously dition Fire ted and or and/or nper ted on ce meet m will be red eted on e or to the the utside added to ding veekly x bliance.		

, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ALBERT LEA GOOD SAMARITAN CENTER			(X3) DATE SURVEY COMPLETED	
		245441	B. WING	i		02/	09/2023
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		7	TREET ADDRESS, CITY, STATE, ZIP CODE 5507 240TH STREET LBERT LEA, MN 56007		
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K 372 K 374		ge 9 ling Spaces - Smoke Barrie		372 374	Improvement Committee for review further recommendations.		3/16/23
SS=F	Subdivision of Build Doors 2012 EXISTING Doors in smoke barbonded wood-core resists fire for 20 m plates of unlimited are permitted to har assemblies per 8.5 automatic-closing, are not required to egress travel. Door clear width of 32 indoors. 19.3.7.6, 19.3.7.8, This REQUIREMENT by: Based on observation facility failed to main per NFPA 101 (201 sections 19.3.7.8 are finding could have a residents within the Findings include: On 02/09/2023 betwit was revealed by a smoke barrier door greater than 1/8" the	rriers are 1-3/4-inch thick solid doors or of construction that inutes. Nonrated protective height are permitted. Doors we fixed fire window. Doors are self-closing or do not require latching, and swing in the direction of opening provides a minimum ches for swinging or horizontal 19.3.7.9 NT is not met as evidenced tion and staff interview, the ntain the smoke barrier doors 2 edition), Life Safety Code, and 8.5.4.1. This deficient a widespread impact on the facility. Ween 1000 AM and 0300 PM, observation that the following assemblies exhibited air-gap at would allow the passage of 300, and 600; adjacent to the			K374- NFA 101 Subdivision of Buil Spaces- Smoke Barrier Doors Corrective action will include: 1. The Maintenance Director or designee will adjust or repair the sbarrier doors on Wings 100, 300, at o meet NFPA requirements. Compon or before 03/27/2023 2. The Maintenance Director and designee will conduct routine inspend maintenance of smoke rated of Beginning 03/01/2023 3. The facilities preventative maintenance program will be verificated annual Smoke Door Inspectompleted 03/07/2023	moke and 600 oleted or ections doors.	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ALBERT LEA GOOD SAMARITAN CENTER (X3) DATE SU COMPLET					
		245441	B. WING			02/	09/2023
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K 374		ge 10 e Maintenance Director nt finding at the time of	K 3	74	Assurance of On-Going Complianc 1. It our policy to inspect and main smoke doors as part of our prevent maintenance program. The Mainten Director will conduct at a minimum inspections and maintenance of fire smoke rated doors. Completed 03/01/2023 2. The facility safety committee wireview and oversee documentation shows that the aforementioned inspections are performed annually required for a period of 1 year. Beging 03/01/2023 3. The facility administrator will main and verify annual smoke door inspeare completed and documented performed.	ntain tative nance annual e and that as inning	
	Electrical Systems Maintenance and To The generator or or and associated equiservice within 10 secriterion is not metroprocess shall be process shall be processed in the shall be processed	- Essential Electric System esting ther alternate power source ipment is capable of supplying econds. If the 10-second during the monthly test, a ovided to annually confirm this e safety and critical branches. esting of the generator and re performed in accordance inspected weekly, exercised tes 12 times a year in 20-40 xercised once every 36 uous hours. Scheduled test ns include a complete		918	assigned PM scheduling. Beginning 03/01/2023		3/24/23

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ALBERT LEA STREET ADDRESS, CITY, STATE, ZIP CODE 76507 240TH STREET ALBERT LEA, MN 56007 REGULATORY OR LSC IDENTIFYING INFORMATION) K 918 Continued From page 11 simulated cold start and automatic or manual transfer of all EES Is Slads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Typs 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power directives. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6. 4.4, 6.5.4. 6.8.4. (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Nealth Care Facilities Code, section 6.4.1.1.6.1, 6.4.4.1, 6.4.4.2 and NFPA 110 (2010 edition) 18.4, 8.4.9.8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the required once every The facility preventative maintenance STREET ALBERT LEA, MN 56007 ABJERCH CORRECTIVE, STATION, DEPA ABJERCH CORRECTIVE, ALTON SCREETION, DEPGENCE, TAIL BERCH LEA, MISCORDE, SCREETION, DEPGENCE, DEPGEDER AND SC	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG 01 - ALBERT LEA GOOD SAMARITAN	(X3) DATE SURVEY COMPLETED		
GOOD SAMARITAN SOCIETY - ALBERT LEA 75597 240TH STREET ALBERT LEA, MN 56007			245441	B. WING		02/09	9/2023
K 918 Continued From page 11 K 918 simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.4.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition). Health Care Facilities Code, section 6.4.1.1.6.1, 6.4.4.1, 6.4.4.2 and NFPA 110 (2010 edition) 8.4.9, 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the required once every PREFIX TAG K 918 NFPA Electrical Systems 1. The Environmental Services Director and/or designee will schedule the 36 month 4 hour load bank test normally required for Type I generators. Scheduled on 3/24/23. 2. The 36 month 4 hour load bank test will be completed on 3/24/23. 2. The facility maintenance or orgam will be updated to include the Type I 36 month 4 hour load bank test completed: 3/7/23 2. The facility maintenance			- ALBERT LEA		75507 240TH STREET	•	
simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.6.1, 6.4.4.2 and NFPA 110 (2010 edition) 8.4.9.8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by a review of available documentation was presented to confirm that the required once every assurance of On-going Compliance: 1. The facility maintenance program will be updated to include the Type 136 month 4 hour load bank test. Completed: 3/7/23 2. The facility preventative maintenance	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	COMPLETION
36 months - 4 hour continuous run of the emergency generators is being completed. An interview with the Maintenance Director program will flag the Type I 36 month 4 hour load bank test one month prior to the due date for our inspection to follow up with our vendor for scheduling the test to	K 918	simulated cold startransfer of all EES competent personnestored energy power accordance with Nicircuit breakers are program for periodic components is estarmanufacturer requimaintenance and to readily available. Ecircuits are marked separate from normathe possibility of dasource is a design installations. 6.4.4, 6.5.4, 6.6.4 (111, 700.10 (NFPA This REQUIREMED by: Based on a review and staff interview, on-site emergency 99 (2012 edition), is section 6.4.1.1.6.1, (2010 edition) 8.4 finding could have residents within the Findings include: On 02/09/2023 betwit was revealed by a documentation, that presented to confirm 36 months - 4 hour emergency general emergency gener	t and automatic or manual loads, and are conducted by nel. Maintenance and testing of the sources (Type 3 EES) are in FPA 111. Main and feeder inspected annually, and a scally exercising the ablished according to rements. Written records of testing are maintained and ES electrical panels and large of the emergency power consideration for new NFPA 99), NFPA 110, NFPA 70) NT is not met as evidenced of available documentation the facility failed to test the generator system per NFPA Health Care Facilities Code, 6.4.4.1, 6.4.4.2 and NFPA 110.9, 8.4.9.2. This deficient a widespread impact on the facility.		K918: NFPA Electrical Systems-Essential Electrical Systems 1. The Environmental Services Di and/or designee will schedule the month 4 hour load bank test norm required for Type I generators. So on 3/7/23. 2. The 36 month 4 hour load bank be completed on 3/24/23. Assurance of On-going Compliance 1. The facility maintenance program be updated to include the Type I 34 hour load bank test. Completed 2. The facility preventative mainter program will flag the Type I 36 month our load bank test one month pridue date for our inspection to follows.	ally cheduled test will 6 month 1: 3/7/23 nance onth 4 or to the w up	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING 01 - ALBERT LEA GOOD SAMARITAN CENTER				COMPLETED	
		245441	B. WING	i		02/	09/2023	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY			7	TREET ADDRESS, CITY, STATE, ZIP CODE 5507 240TH STREET LBERT LEA, MN 56007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 920	Electrical Equipment CFR(s): NFPA 101 Electrical Equipment Extension Cords Power strips in a particular patient-care-related (PCREE) assemble by qualified personnt 10.2.3.6. Power strips for non-PCRE meet UL 13 strips for non-PCRE (outside of vicinity) care rooms, power standards. All power standards. All power standards. Extension cords used immediately upon converted to the converted to the cords are composed to the cords are substitute for fixed to the cords are composed to the cords are cords are cords are cords are cords. All power cords are cords. All power cords are cords. All power cords are cords are cords are cords are cords are cords are cords. All power cords are cords. All power cords are cords. All power cords are cords. All power cords are cords. All power cords are	nt - Power Cords and Extens ont - Power Cords and ontient care vicinity are only	KS	918	ensure compliance with NFPA Electory System regulations. 3. This test will also be added to out vendor's automatic scheduling system. This will be audited weekly x 4 at monthly x 3 to ensure compliance. Results will be brought to the quality assurance and performance commendations.	ir em. nd y ittee	3/16/23	
	by:							

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ALBERT LEA GOOD SAMARITAN CENTER			(X3) DATE SURVEY COMPLETED	
		245441	B. WING		02/	09/2023	
NAME OF I	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>		
COODC		AL DEDT LEA		75507 240TH STREET			
GOOD S	AMARITAN SOCIETY	- ALBERT LEA		ALBERT LEA, MN 56007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE	(X5) COMPLETION DATE	
K 920	facility failed to man and cables in accordition), Health Car 10.2.3.6 and NFPA Electrical Code, secondition could have residents within the Findings include: On 02/09/2023 betwit was revealed by a Station 4, a full-size powered by an external external contents.	tion and staff interview, the hage usage of flexible cords dance with NFPA 99 (2012 te Facilities Code, section 70, (2011 edition), National ctions 400-8(1). This deficient e an isolated impact on the facility. I ween 1000 AM and 0300 PM, observation, that at Nurses ed refrigerator was being	K 9	K920 Electrical Equipment – F Cords and Extension Cords It is the policy of the facility to r usage of all Power/extension C power strips in accordance with standards and requirements. A this facilities credible allocation compliance and correct the cital Corrective action will include: 1. The Environmental Service and or designee will remove th cord in use at Nurse Station 4. 03/24/2023 2. Scheduled to have outlet in electrical contractor. Complete 03/07/2023 3. Work will be completed 03 Assurance of On-Going Comp 1. The Environmental Service and/or designee will conduct o power extension cords, power power surge protector inspection assure NFPA standards and re and as identified in our prevent maintenance program. 2. The facility safety committe review and oversee documents shows that the aforementioned inspections are performed as r The committee will monitor and cord inspections. Beginning on 03/01/2023	naintain the cords and n NFPA 101 and accept of ation K920 as Director as Director agoing strips and on to quirements ative ative ation that ation that a power and po		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 6, 2023

Administrator Good Samaritan Society - Albert Lea 75507 240th Street Albert Lea, MN 56007

Re: State Nursing Home Licensing Orders

Event ID: N0L211

Dear Administrator:

The above facility was surveyed on February 6, 2023 through February 9, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> 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.

Good Samaritan Society - Albert Lea March 6, 2023 Page 2

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

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

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

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00131	B. WING		02/09/20	023
	PROVIDER OR SUPPLIER	- ALBERT LEA 75507 240	DRESS, CITY, S DTH STREET LEA, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE CC	(X5) DMPLETE DATE
2 000	In accordance with 144A.10, this corrected pursuant to a surve found that the deficit herein are not corrected shall like with a schedule of the Minnesota Departments of the Minnesota Departments of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected. You may request a that may result from orders provided that the Department with notice of assessments.	nether a violation has been compliance with all rule provided at the tag alle number indicated below. It is several items, failure to the items will be considered ack of compliance upon any item of multi-part rule will ment of a fine even if the item aring the initial inspection was the awritten request is made to an 15 days of receipt of a ant for non-compliance.	2 000			
	conducted at your faminnesota Department facility was found to MN State Licensure orders were issued.	S: 2/9/23, a licensing survey was acility by surveyors from the ent of Health (MDH). Your be NOT in compliance with a The following licensing. Please indicate in your orrection that you have				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Electronically Signed

03/16/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
	00131	B. WING		1	C 09/2023	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY	- ALBERT LEA 75507 240	DRESS, CITY, S TH STREET LEA, MN 560	STATE, ZIP CODE			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
The following complete survey; H54418291C (MN8-H54418290C (MN8-H54418290C (MN8-H5441070C (MN81-H5441070C (MN81	ers, and identify the date when ed. laints were reviewed during 4052) 4072) 3326) 768) ent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for e assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" s the "To Comply" portion of . This column also includes re in violation of the state tement, "This Rule is not met llowing the surveyor 's gested Method of Correction Correction. participate in the electronic nsure orders consistent with artment of Health in 14-01, available at ate.mn.us/divs/fpc/profinfo/inf licensing orders are	2 000				

Minnesota Department of Health

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING:			COMPLETED	
		00131		B. WING		02/0) 9/2023	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	STATE, ZIP CODE	•		
INAIVIL OI I	NOVIDEN ON GOLT LIEN			TH STREET				
GOOD S	AMARITAN SOCIETY	- ALBERT LEA		_EA, MN 56				
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2 000	Continued From page	ge 2		2 000				
	be corrected prior to the Minnesota Depa is enrolled in ePOC not required at the k state form.	artment of Health. and therefore a si	The facility gnature is					
	PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEAR	N OF CORRECTION OF CORRECTIONS OF CORRECTION	ON." THIS ES ONLY.					
2 900	MN Rule 4658.0525 Ulcers	Subp. 3 Rehab -	Pressure	2 900			3/22/23	
	Subp. 3. Pressure comprehensive resions of nursing services development of a nursing services development of a nursing services.	dent assessment, must coordinate th	the director e					
	A. a resident who without pressure sores unle condition demonstrates, that the	ess the individual's ates, and a physici	elop s clinical an					
	B. a resident we receives necessary promote healing, pronew sores from devi	event infection, ar	rvices to					
	This MN Requirements by: Based on document interview, facility portant manufacturer guide ensure an assessments	t review, observati licy review, and rev lines, the facility fa	on, and view of iled to		F686: Plan of Correction Director of Nursing provided educated R10 and her daughter regarding the increased risk of pressure ulcer			

Minnesota Department of Health

STATE FORM N0L211 If continuation sheet 3 of 18

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED				
					c				
		00131	B. WING	_	02/09/2023				
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE					
00000		75507 2	40TH STREET						
GOOD S	AMARITAN SOCIETY	- ALBERT LEA ALBER	TLEA, MN 56	007					
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(* 33)				
PREFIX TAG	•	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)					
2 900	Continued From pa	ige 3	2 900						
	of a foam cushion p	placed on a pressure reducing		development related to using a foa	am				
		to follow manufacturer		mattress topper on 2/9/23. Daughter and					
	•	se of a "Panacea Original		resident have chosen to keep foar					
	` •	re reducing)" for 1 of 3		mattress topper. R10 s care plan					
	` ,	iewed for pressure ulcers. potential for R10, who was at		been updated to include assisting with repositioning every 2 hours an					
	·	ment of pressure ulcers, to		resident has not done so individua	- I				
	•	ulcer (area of skin breakdow	n	Nursing management reviewed all	·				
	• •	ressure). In addition, the		residents in facility and ensured th					
	facility failed to comprehensively assess and			documentation of education provided to					
	•	tions to prevent worsening an	d	those residents that do not have the					
		itional pressure ulcers (PU)'s		facility issued pressure reducing n					
	. •	1 of 3 residents (R124)		or additional padding on their pad.					
	reviewed for pressu	ire dicers.		Residents who chose to not use the facility s pressure reducing mattress or					
	Findings include:			use extra padding on their mattres					
	i mamge merade.			educated at least quarterly on the					
	Review of a docum	ent provided by the facility		increased risk of development of p	ressure				
	,	cer/Wound Care Resource		ulcers related to this choice. Care	<u>-</u>				
	,	26/22, indicated "Based on		will be updated to include a turning	′				
	•	assessment of a resident, the		repositioning schedule per the res	ident⊡s				
		thatA resident who enters		individual needs.	ho				
	•	ressure ulcers does not lcers unless the individual's		Nursing staff will be educated on t importance of educating residents					
	• •	emonstrates that they were		increased risk of pressure ulcers v					
	unavoidable"	,		using the facility□s pressure reduc					
				mattress. Education will occur via					
		ent provided by the facility		meeting to occur on 3/16/23.					
	,	am MattressOwner's		R124 has discharged from the fac	_				
	·	" Never alter this product in	ו	All residents at risk for pressure ul					
		of component of a Panacea used with non-Panacea parts		were reviewed to ensure that there appropriate care planned intervent					
	or components"	•	'	promote the healing of current pre					
	5. 55111pontonto			ulcers and to prevent skin breakdo					
	Review of R10's ele	ectronic medical record (EMR)	occurring.					
		Profile" tab indicated the		Nursing staff will be educated on e	nsuring				
		ted to the facility on 09/04/19,		care planned interventions for the					
		generalized muscle		prevention and treatment of press					
	weakness.			ulcers are in place and the importa					
				providing ongoing education to res	idents				

Minnesota Department of Health

STATE FORM N0L211 If continuation sheet 4 of 18

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				A. BUILDING:			
		00131		B. WING		02/0	9/2023
NAME OF	PROVIDER OR SUPPLIER	5	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	SAMARITAN SOCIETY	- ALBERTLEA	75507 240	TH STREET			
	- AMARIAN SOCIETI	- ALDLINI LLA	ALBERT L	EA, MN 56	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 4		2 900			
	the "Care Plan" tab the resident had the skin integrity due to urinary incontinence provide R10 with a Review of R10's EN Predicting Pressure "Assmts (Assessme indicated the reside development of pre	AR "Care Plan," located and dated 08/24/20, in potential for impairmed decreased mobility and the intervention was pressure reducing materials. The intervention was pressure reducing materials. Braden Scale for each of the and dated 09/21/21 tab and dated 09/21/21 tab and dated 09/21/21 tab and dated 09/21/21 tab and the development of the development as at risk for the development.	ndicated ent to id s to tress. nder the /30/22, of under		via a meeting to occur on 3/16/23. Random audits to ensure compliate be conducted by nursing manager weekly x 4 and monthly x 3. Audit will be brought to the Quality Assurer Performance Improvement Comment Review.	nce will ment t results rance	
	Review of R10's EMR quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/23/22, indicated a "Brief Interview for Mental Status (BIMS)" score of 11 out of 15 which revealed R10 was moderately cognitively impaired. The assessment indicated R10 required extensive assistance of one staff for bed mobility and transfers and was at risk for the development of pressure ulcers.						
	pointed to her mattring in pain due to the permission for the semattress. The cover cushion topper was reducing mattress.	on 02/07/23 at 9:00 at ess and stated her bactor mattress. R10 gaves urveyor to examine the observed on a pressurable and a fortable.	ck was e e am ire er family				
	nursing assistant (Note were both familiar value) stated they were aways	on 02/08/23 at 8:06 a. IA)-K and NA H stated with R10. Both NA K are are of the foam cushind were aware the res	they nd NA H on on				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		00131		B. WING			C 09/2023
	PROVIDER OR SUPPLIER	- ALBERT LEA	75507 240	DRESS, CITY, S OTH STREET LEA, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCE MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From paramily brought the forms an interview director of nursing (aware R10 had a formattress. DON N strong for the development was made for document was benefits were and/or her family. A subsequent intervent of the use potentially could lead the stated she needed to resident's family and the continued use of the continued use pressure reducing to the R124	oam cushion toppe on 02/08/23 at 2:58 (DON) stated she was at each the resident was asked if R10 and dinformation on rise of a foam cushion at to a pressure ulcate to get in touch with direview the clinical provided by the ensed the risk versue of a foam cushion	5 p.m., the as not to her as at risks e resident 02/09/23 at or her sks verses which er. DON the I records. d of the s benefits	2 900			
	R124 was admitted diagnoses (identifier order sheet) dated a kidney disease (the excess fluid from the (change in average and unstageable profull thickness tissue or estimated, dry and leather hard, dry and leather the control of the excess fluid from the control of the excess fluid from the excess fluid fl	d on the active phy 2/8/23, including; classification kidney fails to filter e blood) altered me mental function) we loss but is either classification and eschar is dead to	sician ronic waste and ental status eakness that has overed by ue is ssue that is				
	R124's admission n	ninimum data set (l	MDS)				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00131		B. WING		C 02/09/2023	
	PROVIDER OR SUPPLIER	- ALBERT LEA	75507 240	DRESS, CITY, S OTH STREET LEA, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOOD CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE	
2 900	having a baseline in (BIMS) of "14" (cog assistance with acti that included dressi positioning and wal R124 as being at ris unhealed unstagea Interventions include PU care. Review of the admit dated 1/18/23, identified Functions a minimum drainage (thin pink tissue is pink in cold (absorbent dressing applied. Review of a wound 1/21/23, identified for its pink in cold (absorbent dressing applied. Review of a wound 1/21/23, identified for its pink in cold (absorbent dressing applied. Review of a wound 1/21/23, identified for its pink in cold (absorbent dressing applied. Review of a wound 1/21/23, identified for its pink in cold (absorbent dressing applied. Review of a wound 1/21/23, identified for its pink in cold (absorbent dressing applied.	1/24/23, identified R1 nterview for mental stantively intact). R124 vities of daily living (Aing, toileting, transferking. The MDS identified R10 and identified R124 as having the right heel. data collection tool of R124 as having a unsant in the PU and amount of serosang watery fluid) and surror. A Mepilex dressing used for wound extend the extending a PU and a collection tool of R124 as having a PU and a collection tool of R124 as having a PU and a collection tool of R124 as having a PU and a collection tool of R124 as having a PU and T24 as having a PU and T25 as having a PU and T26 as	tatus required ADL's) tified ified a ress and form tated tageable by 2.0 cm area. The uinous rounding gudate) lated J on the leters a depth. W le The PU ous in color. A	2 900			
	1/27/23, identified F	R124 as having a PU ced complaints of pa	on the				

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		l `´	E CONSTRUCTION	 ` '	(X3) DATE SURVEY COMPLETED	
				A. BUILDING:			_	
		00131		B. WING			C 09/2023	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOODS	SAMARITAN SOCIETY	- ΔΙ RERT I FΔ	75507 240	TH STREET	•			
	AMAKITAN SOCILI I	- ALDLINI LLA	ALBERT I	LEA, MN 56	007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY I SC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 7		2 900				
	length by 4.0 cm with has 90% granulation has a moderate am (white, yellow or browninfection) and skin is breaking down of slice and 1/30/23, identified Fright heel. The PU recommend the commendation of the purished that is the purished that is the purished from the purished that is the purished that is the purished from the purished that is the purished from the purish	data collection tool de 124 as having a PU measured 4.0 cm lenges sement did not include PU bed. The PU has sing and the tissue	The PU he PU age a sign of and and the gth by 3.1 de the					
	2/1/23, identified R1 right heel. The PU recommendate of the commendate of the comme	date collection tool date leading a PU of measured 4.0 cm lenguas described as have already as a moderate a sinage and the skin make a leading a leadi	on the gth by 3.1 ing 100% amount of argins with					
	2/5/23, identified Raright heel. The PU recommendate and 0.1 cm width and 0.1 cm the PU bed were not minimum amount of surrounding tissue.	date collection tool do 124 as having a PU of measured 3.7 cm length of depth. The charact of described. The PU of serous drainage and noted to be macerate orb to wound base are x.	n the gth by 5.4 eristics of had a d					
	1/18/23, included or	nt physicians orders rders to reduce and e to the right heel and						

Minnesota Department of Health

	NT OF DEFICIENCIES N OF CORRECTION			l ` ´	E CONSTRUCTION	· , ,	(X3) DATE SURVEY COMPLETED	
		00131		B. WING			C 09/2023	
	PROVIDER OR SUPPLIER	- ALBERT LEA	75507 240	DRESS, CITY, S OTH STREET LEA, MN 560				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
2 900	Avoid positions that Place cushions or pressure. Check we infection, redness sand administer Oxy severe pain) 5 mg k. Review of a provided 1/24/23, by certified indicated R124 was R124's PU of the rigidentified the PU to (Partial thickness loshallow open ulcer without slough. May open/ ruptured blist granulation tissue. It edges. Treatment of (aids in debridement damaged tissue and environment) with fewith kerlix. Change (PRN). Review aga (antibiotic) and control note further indicate wound nurse will be Review of a physicil included lodosorb tright heel, due to not current treatment. Review of the care identified R124 as her R124 is at risk for finded assess/redaily on the wound	ition for a long period can make the PU would willows under legs to round daily for signs of welling and increase codone (used for mode of twice daily) for Post of the heel as a stage 2 as of dermis present with a red-pink wound also present as an iter) with some eschalarythema around the orders to apply Medihold, of which is the remain derivides a moist here are deresting daily and as in in 2 days. Start Docinue offloading. The ed the NH (nursing here	orsen. reduce of d pain oderate to U pain. dated CNP)-A, ange in as notes 2 ulcer ing as a d bed, ntact or r and oney noval of ealing and wrap s needed exycycline progress ome) 23, n the the /23, ght heel. ie to rventions healing I to	2 900				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	1 ` ′	(X3) DATE SURVEY COMPLETED	
		00131		B. WING			C 09/2023
NAME OF	PROVIDER OR SUPPLIER	S	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GOOD	SAMARITAN SOCIETY	- ALBERT LEA		TH STREET			
0(4) 15	CLIMMA DV CTA		ALBERT	_EA, MN 560		CORRECTION	()/(5)
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2 900	Continued From pa	ge 9		2 900			
	remind the resident every 2-3 hours and with the blue foam le resident with socks sock aid or shoe how may be difficult for le R124 has pain in the	am boots and/or pillow to change positions at to not stand up or transport on. Staff to assist and shoes. R124 may ner due to her right hee e right heel ulcer and stand shoes of the pain median.	least nsfer the use a but el PU. staff to				
Observation and interview on 2/7/23, at 9:30 a.m. R124 was sitting in her recliner with her feet dependent to the floor. The residents right lower leg and foot was slightly swollen. The right foot had a gripper sock on. Both heels were resting on the floor. R124 stated she had a PU on her heel. There was a protective heel boot sitting next to her bed. R124 stated she wears the protective boot to her right foot during the night, but does not wear during the day. R124 indicated she usually has her tennis shoe on but needed help to get it on. R124 further indicated she did not elevate her feet or have her feet off the floor during the day, rather just during the night when in bed. R124 stated it was too difficult to elevate the footrest herself.							
	treatment was done (DON). R124's right dressing was remove to be tight and difficate resident complaining was covered with next tissue was pink with peeling skin. After a staff assisted with pession back on. President complaining was covered with peeling skin. After a staff assisted with personal contractions and contractions are contracted with peeling skin. After a staff assisted with personal contractions are contracted with peeling skin. After a staff assisted with peeling skin. President complaining the contraction of the contraction	23 at 10:30 a.m. R124 by the director of nurse sock, tennis shoe and red. The sock and shoe ult to remove due to the gof pain. The PU on the crotic tissue and surrelation and new dressing was appointing the residents so sure and friction was reshoe on and a metal second	sing d e noted he heel bunding d plied, ck and equired				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00131	B. WING		C 02/09/2023	
GOOD SAMARITAN SOCIETY - ALBERT LEA 75507 24	DDRESS, CITY, ST OTH STREET LEA, MN 5600			
(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 SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
horn was used on the heel to get the shoe on. The shoe horn was pressed against part of the pressure ulcer. Interview with the resident at this time, stated that she had been wearing her shoes for at least a week and she has been having a lot of pain when having her sock and shoes put on and taken off. Observation on 2/9/23, at 9:00 a.m. R124's PU treatment was done by registered nurse (RN)-B. R124's tennis shoe, sock and dressing was removed from the right foot. R124 clenched her teeth and complained of pain when this was done. There was a moderate amount of brownish colored drainage on the dressing (Isosorb has a brownish color) R124's PU was observed to be covered with necrotic tissue. When RN-B cleansed the PU, R124 flinched and complained of pain. The tissue around the PU noted to be macerated with peeling skin. There was also a 1.0 inch diameter discolored area in the skin above the PU on the right heel. RN-B indicated this was a change in the tissue. The PU measured 3.4 cm length by 4.6 cm depth. RN-B also indicated R124 received Oxycodone for pain prior to the dressing change at 5:30 a.m., but still had a lot of pain with treatment. Because R124 complained of increased pain when putting on and removing the sock and tennis shoe, R124 agreed to put on a gripper sock at this time. Observations over the course of the survey on 2/6/23 through 2/9/23, R124 was observed to be sitting in her recliner with both of her feet/heels on the floor. R124 was wearing tennis shoes during observations on 2/7/23 through 2/9/23. When interviewing R124 again on 2/8/23, at 2:00 p.m. she confirmed she did not elevate her legs or have her feet off the floor when up during the day. R124 indicated she could not get the foot pedals				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:	A. BUILDING:			
	00131	B. WING	_		C 09/2023	
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY	75507 2	40TH STREET	•			
GOOD SAMAKITAN SOCIETI	- ALBERT LEA ALBER	T LEA, MN 56	007			
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2 900 Continued From page	age 11	2 900				
and offer to assist. assist her with wea R124 indicated she	erself and staff do not come in R124 stated the staff did aring protective boots at night. wanted to go home and to help the PU heal, so that					
(NA)-A confirmed the day with her fe NA-A indicated she the right heel, but other than the nurs	R, at 1:30 p.m., nurse aide R124 sits in her recliner most et/heels touching the floor. was aware of R124's PU on was unsure of any intervention se changing the dressing to the other verified R124 wears her ghout the day.	ıs				
confirmed R124 specification her recliner with he she was not aware day, but was aware boots at night whe	s, at 11:00 a.m., NA-B bends a lot of the day sitting in er feet down. NA-A indicated of any interventions during the e that R124 wears protective in in bed. NA-B further verified shoes throughout the day.	е				
R124's PU on the RN-B indicated R1 covering R124's entire PU is confirm sock and shoes or pressure and friction increased pain for indicated when R1	s, at 9:00 a.m., RN-B indicated right heel has not improved. 24 did not have necrotic tissue attire PU on admission, but now vered with necrotic tissue. The ed it was difficult taking R124's and off due to causing on on the PU, that caused the resident. RN-B further 24's PU was identified to the provider was notified and and that had been done.	e V S				
therapist (PT)-A ,s	at 9:20 a.m. physical tated R124 has been wearing admission, that she was					

Minnesota Department of Health

STATE FORM NOL211 If continuation sheet 12 of 18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IMBER: ` ´	PLE CONSTRUCTION G:	` '	(X3) DATE SURVEY COMPLETED	
	00131	B. WING _		02/0) 9/2023	
NAME OF PROVIDER OR SU		STREET ADDRESS, CITY 75507 240TH STREE ALBERT LEA, MN 5	ET .			
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIENCIENCY MUST BE PRECEDED BY	Y FULL PREFIX	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
R124's shoes shoe horn, to off. PT-A indicated when independent been a intercoptions and been discuss well as safety indicated this linterview on indicated R1's even when expendent to wear her to the result of the walking to the confirmed shor family relative to the confirmed shor family relative to the resource on linterview on she was awas shoes, even indicated stap prevent wors always compand the result of the resul	T-A indicated she had been assist with putting the she icated she was unaware of was located on the heel. It was given the okey in her room, there should isplinary discussion with not be condition of the PU condition of the resident with walking had not been done. 2/9/23, at 9:30 a.m. with Reference therapy allowed R124 to y (about a week ago) R12 dennis shoes due to the risk and to put on her shoes of the bathroom and to meals are did not review the risks are day and not elevating her had to wearing the tennis shoe day and not elevating her had implemented interventing of the PU, but R124 and implemente	r a metal oe on and of exactly PT-A to walk d have nursing. uld have the PU as ng. PT-A RN-C shoes, -C o walk 4 started x of falling. be too on, when RN-C with R124 shoe er legs. en given for comote less CON stated tennis The DON entions to did not A should R124 to and other				

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00131	B. WING			C 09/2023
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
GOODS	SAMARITAN SOCIETY	- ALBERT LEA	240TH STREET T LEA, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 13	2 900			
	Ulcer Prevention and 4/26/22, indicated the appropriately use progressure redistributed residents at risk for interdisciplinary tear modifications that a plan of care. Interventions that may be impacted interventions should residents goals. Edithe resident and/or not determine to be ulcer should show sto 4 weeks. Signinclude decrease in and improvement in slough to granulation makes an informed interventions, then what the risk of the outcome should be and/or family. The editector of nurse review all residents assure they are reconstructed. SUGGESTED MET The director of nurse review all residents assure they are reconstructed and those affected and those affected to ensure affected and those affected to ensure affected to ensure affected and those affected and those affected to ensure affected and those affected to ensure affected and those affected and t	Skin Assessment Pressure and Documentation, dated the purpose of the policy is to revention techniques and ion surfaces on those PU. The policy indicated the mishould determine any reinecessary to the residents entions should focus on and psychosocial aspects ed. Treatments and the consistent with the family. If a pressure ulcer is clinically unavoidable, the signs of improvement might size, decrease in exudate in tissue (from necrotic to an to epithelial) If a resident choice to refuse treatment of education of what a PU is, refusal is, and the potential provided to the resident education should be HOD OF CORRECTION: The policy indicated the missure ulcers to every the pressure ulcers to every the pressure ulcers to every the prevent pressure ulcers to be appropriate care and services and reduce the risk for pressure and reduce the	r			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00131	B. WING		C 02/09/2023	
		00131			02/0	3/2023
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ALBERT LEA	TH STREET LEA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	O Continued From page 14		2 900			
	bring all audit inform Assurance Perform	The DON or designee should nation to the Quality ance Improvement (QAPI) nine compliance or the need g.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21665	MN Rule 4658.1400	Physical Environment	21665			3/22/23
	functional, comforta environment, allowi	ust provide a safe, clean, able, and homelike physical and the resident to use as to the extent possible.				
	by: Based on observation review, the facility for recommended superprevent choking for reviewed for accident accident findings include: Review of R45's electitled "Admission Recommended superprevent choking for reviewed for accident accident for the facility of R45's electitled "Admission Recommended "Profile" tab, indicated the facility on 08/dysphasia (difficulty). Review of a document titled, "Diet Notificated indicated the level of "Line of Sight."	ervision during meals to 1 of 3 residents (R45) nt hazards. ectronic medical record (EMR) ecord," located under the ed the resident was admitted 25/22, with a diagnosis of		F689: Plan of Correction: R45□s care plan was reviewed and continues to eat meals in main din room with distant line of sight super R45 was re-evaluated by speech to on 2/16/23 and his care plan was with her recommendations. The care plans, dietician assessments applicable) were reviewed for all restored to ensure all residents were eating location to provide the necessary supervision to meet their needs. A plans were updated if applicable, level of supervision needed for restored additional reminder to staff. Nursing staff will be educated on the importance of supervision for residuence and a supervision for residue	ervision. herapy updated ents, (when esidents in a All care The sidents ds as an he dents	

Minnesota Department of Health

STATE FORM N0L211 If continuation sheet 15 of 18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00131	B. WING		C 02/09/2023	
NAME OF	PROVIDER OR SUPPLIER	STREE	ADDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ALBERTLEA 75507	240TH STREE	Τ		
<u> </u>	AWARITAN SOCILIT	- ALBENT LLA ALBEI	RT LEA, MN 56	5007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
21665	Continued From pa	ge 15	21665			
21665	titled, "Physician Or indicated the reside Supervision During Record review of a written by the Speed indicated a recommerceive "line of seen couraged to eat it." Record review of Reunder the tab "Care indicated intervention nutrition/hydration point sight" supervision. Record review of Reunder the tab "Care indicated intervention nutrition/hydration point sight" supervision. Record review of Retherapist Summary written be indicated a recommendated a recommendated a recommendated a recommendated and system of s/s [signs and system of	rders," dated 08/26/22, ent could have "Distant Meals/PO [oral] Intakes." "Diet Notification Form," ch Therapist (ST) on 09/21/2 nendation for the resident to sight " supervision and be not the dining room. 45's EMR "Care Plan," local Plan" and dated 09/26/2022 ons for the resident's problems involved "line of the ST on 10/20/2022, nendation for the resident to be distant supervision and earl for meals to ensure safety neal and monitor for increase mptoms] of aspiration or others " AR titled significant change	22, ed 2, ". at er 2,	risk for choking via a meeting to be on 3/16/23. Random audits to ensure compliate conducted by nursing manage weekly x 4 and monthly x 3. Audi will be brought to the Quality Assu Performance Improvement Commerce Review.	nce will ment t results irance	
	Assessment (CAA) assessment trigger staff to develop a ca	, located under the ed nutrition and directed the				

Minnesota Department of Health

STATE FORM N0L211 If continuation sheet 16 of 18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED				
				A. BUILDING:			_				
		00131		B. WING			C 02/09/2023				
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE						
GOOD SAMARITAN SOCIETY - ALBERT LEA 75507 240TH STREET											
ALBERT LEA, MN 56007											
(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 (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE						
21665	Continued From pa	ge 16		21665							
		in his room eating his o staff present during	•								
	R45 was observed	on on 02/07/23 at 8:13 eating his breakfast m were no staff present.	eal in								
	R45 was observed	on on 02/07/23 at 8:39 eating his breakfast m were no staff present.	eal in								
	nursing assistant (N R45 was at risk of o props the resident's so she can keep an	on 02/09/23 at 7:26 a lA) H stated she was a choking. NA H stated she door open during me eye on him. NA H stated the contact precautain dining room.	aware he altimes ted the								
	_		-								
	nurse manager (NM for the unit manager confirmed she was stated the resident room but currently on contact precautions.)	on 02/09/23 at 10:11 and on the 300 unit and familiar with R45. NM typically ate in the mai eats in his room due to ons. NM D stated the los, outside of his room	D n dining being resident								
	speech therapist (S room with only inter supervision was no	on 02/09/23 at 10:15 T) A stated R45 eating mittent "line of sight" t adequate. ST A state	g in his d her								

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
						С				
		00131	B.	. WING		02/0	9/2023			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET 75507 240TH STREET										
<u> </u>	AMAKITAN SOCILITI	ALB	ERT LEA	A, MN 56007						
(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)					
21665	Continued From page 17			21665						
	to be in the dining resupervision and was at the time of the retherapy. ST A stated information from number improved, leaving the while eating, was not be director of nursing ST A's recommendation one person to sit in	oom with direct "line of sig s based upon her evaluation sident's discharge from sk d without a new evaluation rsing that the resident he resident alone in his roo	on illed or m, the							
	The director of nurse and assess resident choking/aspirating a supervision while earn importance of supereceiving altered directions and assess resident choking/aspirating. The DON or design measurable audits of the delivery of cathose who have the ensure appropriate supervision are importance appropriate supervision are importance supervision are important appropriate su	for a specific amount of ting re to residents affected and potential to be affected to care, services, and lemented. The DON or all audit information to Performance Improvement o determine compliance o	re the the							

Minnesota Department of Health

STATE FORM N0L211 If continuation sheet 18 of 18