Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2023

Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

RE: CCN: 245455
Cycle Start Date: July 20, 2023

Dear Administrator:

On July 20, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, 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

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 October 20, 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 January 20, 2024 (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.

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 13, 2023

Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

RE: CCN: 245455
Cycle Start Date: July 20, 2023

Dear Administrator:

On September 8, 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

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Saint Paul, Minnesota 55164-0970
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 7/17/23 to 7/20/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/17/23 to 7/20/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with NO deficiency cited: H54553662C (MN85540) H54553786C (MN95336) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

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

Electronically Signed | 08/24/2023

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.

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be	F 550		8/25/23

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F 550	Continued From page 2 free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience for 2 of 2 residents (R13 and R14) who required assistance with dining. Findings Include: R13's admission record printed 7/20/23, identified a diagnoses of Alzheimer's disease, vascular dementia and protein-calorie malnutrition. R13's significant change Minimum Data Set (MDS) assessment, dated 5/26/23, identified severe cognitive impairment, and required extensive assist of 1 person with eating. R13 receiving hospice services. R13's care plan dated 6/9/23, identified an activities of daily living (ADL) self care performance deficit and may require up to total feeding and drinking assistance as her participation level in eating and drinking varies. R14's admission record printed 7/20/23, identified a diagnoses of dementia, hemiplegia and hemiparesis (paralysis of half of the body) right non-dominate side following cerebrovascular (affects blood flow to brain)disease, drug induced subacute dyskinesia (involuntary, erratic movements). R14's quarterly MDS assessment dated 5/4/23,	F 550	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F550 1. On 7/20 all nursing staff instructed to not bring R13 and R14 to the dining room until there is someone available to feed them. 2. Staff instructed to not bring any residents that need assistance with feeding to the dining room until someone is available to feed them. 3. DNS or designee will provide education to all nursing staff regarding the policy on "resident assisted dining" and to bring residents to meals only when staff is available to assist with eating. All nursing staff also educated that food must be the	

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F 550	Continued From page 3 included severe cognitive impairment requiring extensive assistance of one to eat. R14's baseline care plan dated 10/18/22, identified an ADL self care performance deficit and requires staff assist of one to drink and eat. During an observation on 7/17/23, during evening meal in the dining room: 5:35 p.m., R13 was in her wheelchair in the dining room with her head down and bent over at the waist dozing off and on. Her pureed meal was sitting in front of her. Nursing assistant (NA)-C and NA-D present at the table assisting two other residents at the same table. 5:57 p.m., R13 continued to sit in her wheelchair at the table with her food in front of her, bending over at the waist and dozing off and on. 5:59 p.m., licensed practical nurse (LPN)-A finished administration of medications, washed her hands and began to assist R13 to eat. Food was not reheated. R13 ate 25% of her meal. During an observation on 7/18/23, during the noon meal in the dining room: 11:37 a.m., R14 was seated in a Broda chair at a table with 2 other residents with her pureed food served and sitting on the table in front of R14. 11:51 a.m., R14 remains seated at the table with meal served and sitting in front of her. Nursing assistant (NA)-A and NA-D were assisting two other residents at the same table. 11:54 a.m., medications were administered with pureed food sitting in front of her at the table. 11:59 a.m., licensed practical nurse (LPN)-B sat down next to R14 and assisted R14 to eat. Food was not reheated. R14 ate 50% of her meal. During interview on 7/19/23, at 10:00 a.m., NA-A	F 550	proper temperature when assisting the residents with eating. 4. DNS or designee will audit residents who require eating to ensure staff is available to assist with feeding and the food is the proper temperature weeklyx4, monthlyx3. Results will be taken to monthly QAPI meetings for further recommendations. Date of Correction – 8/25/23	

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F 550	Continued From page 4	F 550		

indicated the nursing assistants first get all the residents to the dining room, then go back and assist residents with eating. Both R13, and R14 require assistance to eat. NA-A feels they have enough staff to assist residents with meals but first everyone needs to be brought to the dining area. NA-A indicated sometimes one resident might have to wait while staff assist others and they only assist one resident at a time.

During interview on 7/18/23 at 2:25 p.m., LPN-B confirmed R14's meal was not reheated prior to assisting her to eat.

During interview on 7/20/23 at 9:20 a.m., the director of nursing (DON) confirmed residents should have food reheated prior to serving and should not have to wait for assistance with eating.

The facility Resident-Assisted Dining policy dated 4/26/23, included:
- Assist resident to the table as needed
- Ensure the resident is appropriately positioned to promote the ability to eat independently. A resident who is not seated in the proper position may appear to have decreases in strength or coordination.
- Serve resident the meal, checking name and diet on the tray card.
- Place the meal in the line of sight of resident
- Provide special assistive eating devices to residents as per their plan of care.
- Encourage residents in feeding self, assisting as needed, following care plan approaches.
- When assisting the resident, employees are to sit next to the resident; do not stand and feed the resident. Employees can assist two residents and offer assistance as needed.
- Do not rush. You can start with liquids by having

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F 550	Continued From page 5 resident try to use a draw or hold a half-filled glass and drink. With solid foods, have resident start with foods that are easy to get on spoon or fork. Note care plan approaches, which are individualized to the resident. Offer alternatives for items not consumed.	F 550		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine removal of facial hair for 1 of 2 residents (R7) reviewed for activities of daily living (ADLs) who was dependent on staff for cares. Findings include: R7's Admission Record printed 7/19/23, indicated diagnoses including end stage dementia, mood disturbance and anxiety, and polyneuropathy (damage to peripheral nerves with weakness, numbness and burning pain). R7's quarterly Minimum Data Set (MDS) assessment dated 4/6/23, indicated severe cognitive impairment, required extensive assistance of two staff for personal hygiene and no rejection of care behaviors. R7's care plan dated 4/6/23, indicated an ADL self-care performance deficit R/T [related to] functional and cognition deficits and requires one	F 677	F677 1. R7 Shaved on 7/19 after the surveyor told the nursing assistant to shave her. 2. All residents checked for unwanted facial hair 3. DNS or Designee will provide re-education to all nursing staff on proper procedure with removing unwanted facial hair. 4. DNS or designee will audit unwanted facial on resident's weeklyx4, monthlyx3, and results will be taken to monthly QAPI meetings for further recommendations. Date of Correction – 8/25/23	8/25/23

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F 677	Continued From page 6 to two staff assist with personal hygiene, and resident prefers facial hair to be shaved when present requiring assistance of one staff as needed. On 7/17/23 at 2:40 p.m., R7 was observed with varied lengths 1/2 to one inch white whiskers on her chin. During observation on 7/18/23 at 9:14 a.m., R7 was in dining room, well groomed with new clothes on and continued with 1/2 to one inch white whiskers present on her chin. During observation on 7/19/23 at 7:41 a.m., R7 was in the dining room, well groomed with new clothes on. Continued with 1/2 to one inch white whiskers present on her chin. During interview on 7/19/23 at 9:58 a.m., R7 was in bed in her room. R7 indicated she didn't know she had any whiskers present and would like them removed. During interview on 7/19/23 at 10:02 a.m., nursing assistant (NA)-A indicated if R7 has chin hair present. NA- A added should be shaving it off. NA-A indicated they do assist R7 with chin hair removal. During interview on 7/19/23 at 1:35 p.m., NA-C indicated she hadn't noticed R7 had chin hairs and when she notices will ensure they are shaved off. During interview on 7/19/23 at 1:37 p.m., licensed practical nurse (LPN)-B indicated if she notices chin hair on R7 she will let the NA's know. LPN-B added R7 has a little purple razor in her room and	F 677		

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F 677	Continued From page 7 once prompted will use that to shave them off with minimal assistance from staff. During interview on 7/20/23 at 9:20 a.m., the director of nursing confirmed chin hair should be removed as requested and care planned by the resident. The facility Activities of Daily Living policy dated 1/25/22, indicated any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. ADLs are those necessary tasks conducted in the normal course of a resident's daily life.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement bowel movement (BM) protocol for 1 of 1 resident (R8) reviewed for constipation. Findings include: R8's diagnosis report printed on 7/20/23 included history of colon cancer and stroke.	F 684	F684 1. At the time of the survey, R8 had a BM within the last 3 days. 2. At daily standup meeting it was verified that all residents who have not had a BM within 3 days are being given medication or another intervention to promote a BM 3. DNS or Designee will provide	8/25/23

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F 684	Continued From page 8 R8's significant change Minimum Data Set (MDS) assessment dated 5/18/23, indicated moderately impaired cognition, unclear speech, was usually understood and could sometimes understand. R8 who did not walk, required extensive assistance or was totally dependent upon one or two staff for all activities of daily living (ADL's). R8's physician orders included Senna (laxative) tablet 8.6 mg (milligrams); one tablet every 12 hours as needed for constipation. Facility standing orders (written protocols nurses could implement without first obtaining a physician order) for constipation included: 1. Dulcolax suppository (laxative). Insert 10 mg rectally as needed for constipation. Give daily as needed. Contact provider/practitioner if there are three days without a significant BM. 2. Fleet enema (laxative). Insert one application rectally as needed for constipation. One time daily as needed. Contact provider/practitioner if there are three days without a significant BM. 3. Milk of Magnesia Suspension (laxative). Give 30 ml (milliliter) by mouth as needed for constipation. Give daily as needed. Contact provider/practitioner if there are three days without a significant BM. 4. Senna-S (laxative and stool softener). Give two tablets by mouth as needed for constipation. Give up to twice daily as needed. Contact provider/practitioner if there are three days without a significant BM. R8's care plan with revised date of 6/1/23, indicated R8 had a terminal prognosis and to expect changes in elimination. In addition, the care plan with revised date of 6/1/23, indicated	F 684	re-education to nurses regarding procedure for giving medications to residents who have not had a BM after 2 days. Nursing assistants will be re-educated on the importance of charting bowel movements during their shift. 4. DNS or designee will audit the number of days without a BM for each resident and use of medication given to promote a BM weekly x 4 then monthly x 3. Date of correction □ 8/25/23	

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	245455	A. BUILDING _____ B. WING _____	C 07/20/2023

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F 684	Continued From page 9 R8 was on scheduled toileting for fall prevention. During record review, R8 had no documented BM for four days from 6/30/23 through 7/3/23 and again from 7/14/23 through 7/17/23. During an interview on 7/20/23 at 12:05 p.m., together with registered nurse (RN)-A looked at BM documentation in the EMR (electronic medical record). RN-A acknowledged two instances of R8 going four days without a BM in the past 30 days: 6/30/23 through 7/3/23, and 7/14/23 through 7/17/23. RN-A stated the night shift nurse ran a BM report for the previous three days, then posted a note for the day shift nurse if a resident required intervention, such as a stool softener or laxative. RN-A stated a note had not been left for her from the night nurse because R8 had a BM on 7/18/23. RN-A stated the BM report reset every three days, so she was not able to see R8 had not had a BM from 7/14/23 through 7/17/23. RN-A stated most residents had PRN (as needed) orders for a laxative, including R8. RN-A stated a PRN laxative had not been administered to R8 in July. Further, RN-A stated the facility had standing orders for laxatives if needed. Standing orders were reviewed. Each medication listed for constipation also indicated to contact provider/practitioner if there were three days without a significant BM. RN-A could not explain why R8 went four days without a BM with no intervention. During an interview on 7/20/23 at 12:39 p.m., the director of nursing (DON) stated the night shift nurse looked at the BM dashboard in the EMR each day and left a note for the day shift nurse if a resident needed a laxative. The DON stated a resident was to receive prune juice if no BM for	F 684		

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F 684	Continued From page 10 two days and a laxative if no BM for three days. The DON reviewed documentation of R8's BM's in the EMR and verified no BM was documented from 6/30/23 through 7/3/23 and again from 7/14/23 through 7/17/23. Further, the DON stated a laxative had not been administered to R8 in July. The DON stated she expected the night shift nurse to run a BM report and a leave note for day shift nurse to give a laxative if needed. The DON stated resident BM status was discussed Monday through Friday at stand up (morning leadership meeting). The DON stated if R8's lack of BM status had been identified, it would have been communicated to the charge nurses who attended stand up. The DON could not verify if R8's BM's were discussed at stand up as no notes were taken. During an observation on 7/20/23 at 12:50 p.m., R8 was lying in bed awake and not able to answer questions regarding BM's or if he had been experiencing abdominal discomfort. A policy on monitoring BM's was requested and not provided.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		8/25/23

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F 686	Continued From page 11 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess, monitor and implement pressure relieving interventions for 2 of 2 resident (R14, R20) with known risks for pressure ulcer development. R20 developed a stage II pressure ulcer to one heel. Findings include: Stage II pressure ulcers (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.) R20's diagnosis report dated 7/18/23, included recent diagnoses of fracture of left femur and pressure ulcer of left heel. R20's admission Minimum Data Set (MDS) assessment dated 6/22/23, indicated moderately impaired cognition, clear speech, was understood and could understand. R20 required extensive assistance of two staff for bed mobility, transferring and toileting. The MDS indicated R20 was at risk for pressure ulcer and did not have a pressure ulcer. R20's physician or nursing orders included: --7/3/23, Measure left heel wound weekly with treatment and document on UDA (user defined assessment), one time a day every Wednesday. --7/6/23, Wound physician to evaluate and treat left heel wound.	F 686	F686 1. At the time of the survey R20's pressure wound to heel was already identified with a treatment plan in place per a wound care physician. 2. Mirrors placed in resident shower room for nurses to use to effectively assess residents heels while they are in wheelchair/shower chair. Residents with Braden Scale of 17 or less were assessed for proper positioning and routine offloading of bony prominences. 3. Re-education of nursing staff to assess heels and all other bony prominences during bath day and routinely with cares as well as routine repositioning of residents that need assistance. Re-education of licensed nurses of proper procedure for assessing residents Braden scale at the time of admission and follow up policy and procedure for wound identification, physician notification, treatment, and charting. 4. DNS or designee will audit weekly skin assessments to heels are being assessed for skin breakdown weekly x 4, then Monthly x 3. Results will be taken to monthly QAPI committee for further recommendations. Completion date – 8-25-23	

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F 686	Continued From page 12 --7/13/23, Betadine (an antiseptic) to left heel wound one time a day. R20's care plan initiated on 6/29/23, indicated R20 had the potential for pressure ulcer development and a goal was for R20 to have intact skin, free of redness, blisters, or discoloration. Interventions included educating R20 and family as to causes of skin breakdown and provide pressure redistribution mattress. On 7/3/23 and 7/5/23 after the identification of a heel ulcer, additional interventions were added to R20's care plan including: --Avoid positioning R20 on left hip to avoid direct pressure to left heel --Avoid dragging skin across surfaces to prevent friction and shearing --Heel floater when in bed --Prevalon boot (lifts heel off surfaces to prevent pressure ulcers) to left heel when out of bed --Notify nurse of any new areas of skin breakdown noted during bath or daily care During an interview and observation on 7/17/23 at 3:47 p.m., R20 was seated in her recliner in her room and stated she had been in the facility since June due to a fall at home resulting in a fracture to her left leg and was at the facility for rehab (rehabilitation). R20 stated she had a wound on the bottom of her left heel which she got after coming to the facility. R20 stated no one could tell her how she got it and didn't know what they called it. Left foot was wrapped in a soft heel boot and elevated in the recliner. R20's Braden score (a measurement predicting pressure sore risk) on admission dated 6/16/23, was 17, indicating R20 was at mild risk for pressure ulcer.	F 686		

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F 686	Continued From page 13 R20's admission nursing data collection form dated 6/16/23, indicated R20's skin integrity was normal with a surgical incision to left leg. There was no documentation of a pressure ulcer to left heel, or blister or discoloration. A progress note dated 7/3/23 at 1:00 p.m., indicated R20 was found to have an unstageable pressure ulcer on left heel measuring approximately 5.0 cm (centimeter) in diameter. Heel floater and skin prep initiated. Fax prepared for PCP (primary care provider). Fax to provider (P)-C dated 7/3/23, indicated an unstageable pressure ulcer was noted on R20's left heel, measuring about 5.0 cm in diameter. Heel floater added when in bed. Skin prep BID (twice a day). Is this okay? On 7/5/23, P-C replied in writing, "Please consult wound care." R20's pressure ulcer to left heel was first documented in weekly bath-day skin observations conducted by a nurse starting on 7/8/23: left heel pressure area noted; dark purple in color and boggy/blistered/fluid filled. Bath day skin checks prior to that on 6/17/23, 6/24/23 and 7/1/23 did not document heel status. Wound provider note dated 7/13/23, indicated R20 had a stage II pressure wound of the left heel, partial thickness. Duration was noted to be greater than eight days. The wound was healing and measured 4.5 x 4.5 cm; depth not measurable. No exudate. Instructions for staff included to apply Betadine once daily for 30 days and to float heels when in bed. Prevalon boot on left [foot]; wear boot in the morning and off in the evening.	F 686		

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F 686	Continued From page 14 During an interview and observation on 7/18/23 at 1:17 p.m., observed registered nurse (RN)-B apply treatment to pressure ulcer on R20's left heel. RN-B measured the wound area with a paper measuring tape. The pressure ulcer on R20's heel measured 3.5 x 4.5 cm. The circular perimeter was dark in color - almost black - with a lighter variation in the middle; wound depth if any, was not discernable. No open skin or drainage was observed. RN-B stated the left heel pressure ulcer was acquired at the facility after R20 was admitted for rehab following hip survey, adding R20 had not moved around much initially due to pain. RN-B stated it [pressure ulcer] wasn't there, then all the sudden it was. RN-B stated she had conducted bath-day skin checks on R20 prior to the pressure ulcer first being discovered on 7/3/23 and had not observed discoloration or blister to heels. RN-B stated the wound provider had seen R20's heel via telemedicine (use of electronic technology for off-site provider visits). During an interview on 7/18/23 at 1:46 p.m., nursing assistant (NA)-B stated R20 had a shower each week. NA-B explained when a resident was in the shower room, a nurse was called in to conduct a skin check. NA-B stated he also observed a residents skin during cares and had not observed a change in R20's skin prior to the discovery of the pressure ulcer on 7/3/23. During an interview on 7/19/23 at 9:11 a.m., the director of nursing (DON) acknowledged R20's pressure ulcer to left heel was acquired after admission to the facility. The DON stated R20 had hip surgery and was so afraid, she didn't move much in bed. The DON stated nurses did skin checks on bath day, in the tub room while	F 686		

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F 686	Continued From page 15 the resident sat in a wheelchair. The DON admitted there was not a specific prompt on the skin observation tool the nurses used to document skin checks, and further acknowledged it could be challenging to adequately visualize a residents heel while they were seated in a wheelchair. During an interview on 7/20/23 at 8:28 a.m., with the DON and (RN)-C who was also the MDS coordinator, together reviewed R20's Braden assessment, the Nursing Admit Data Collection form -- both conducted on admission on 6/16/23, and R20's care plan. --The Braden assessment form included a section titled Intervention Guide for a resident at mild risk for pressure ulcer development. The guide included "protect heels." --The Nursing Admit Data Collection form had a section titled Skin Integrity which identified care planning considerations for skin and/or wound, including to provide pressure relieving/reducing device and/or skin protective device on heels, elbows, etc. --R20's care plan did not identify interventions to protect skin over bony prominences or repositioning measures until after identification of R20's pressure ulcer. RN-C stated R20 had a pressure mattress and, "I felt that was enough" of a pressure ulcer intervention. RN-C stated R20 had not been on her radar for development of a pressure ulcer because R20 could off-load (minimize or remove weight placed on foot to help prevent and heal an ulcer) since R20 went between her bed and recliner. RN-C stated the interventions listed on the Braden form and the nursing admit data collection form were suggestions - not something the facility had to do. The DON stated in her	F 686		

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F 686	Continued From page 16 opinion, "we needed to have floated her heels." The DON and RN-C admitted there was nothing specific to guide or remind a nurse doing the bath day skin check to ensure heels were assessed, and admitted heels were challenging to assess while a resident was sitting in a wheelchair. During a telephone interview on 7/20/23 at 11:14 a.m., P-C stated if he recalled, R20 had post-surgical puffiness to her left leg when he saw her, and the pressure ulcer may have been a delayed reaction from surgery. P-C was aware there had been no visible evidence of a blister, discoloration, or pressure ulcer to R20's left heel upon admission. A visit note by P-C dated 6/21/23 indicated R20 had edema of bilateral lower extremities, left greater than right. Left lower extremity had +1 edema. The note did not indicate whether P-C had assessed R20's heels. The facility Skin Assessment Pressure Ulcer Prevention and Documentation policy dated 4/26/23, included: -All residents will be identified for their risk of developing pressure ulcers on admission/readmission by a registered nurse using the Braden Scale for Predicting Pressure Sore Risk. -The registered nurse will complete the Braden Scale on all residents quarterly or when the resident has a change in condition that could affect his or her risk of developing an ulcer. -A systematic skin inspection will be made daily by the nursing assistant assigned to those residents at risk for skin breakdown. The nursing assistant responsible for this will report any abnormal findings or signs of skin impairment to the licensed nurse. -Residents who are unable to reposition	F 686		

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F 686	Continued From page 17 themselves independently, as indicated on the Sit-Stand-Walk data collection tool, should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is required for those residents unable to position themselves and is based on nutrition, hydration, incontinence, diagnosis, mobility and observation of the resident's skin over a period of time. The Positioning Assessment and Evaluation is a required tool that is used to determine an individualized repositioning plan. Any resident at risk will be placed on a a pressure redistribution surface as determined appropriate. -If a pressure ulcer is identified, cleanse the area prior to observations being made to allow the wound bed and depth to be more accurately observed. The RN should record the type of wound and the degree of tissue damage on the Wound RN Assessment. The licensed nurse records the location of the area, the measurements and the ulcer/wound characteristics. -Notify the physician/practitioner of the ulcer and resident's condition to obtain order for a treatment. -Dietary is notified by an alert that occurs when the Wound Data Collection is signed and locked. -When a pressure ulcer is present, complete the Wound Data collection tool with documentation to include the following: - An evaluation of the ulcer, if no dressing is present -An evaluation of the status of the dressing; if present whether draining or is leaking) - The status of the area surround the ulcer -The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection.	F 686		

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F 686	Continued From page 18 -If the pressure ulcer is not determined to be clinically unavoidable, the ulcer should show signs of improvement within two to four weeks. -The pressure ulcer should be assessed/evaluated at least weekly and document on Wound RN assessment. Observation of the wound characteristics may be documented by a licensed nurse and should include at least the following: -Measurements - length, width, depth -Characteristics of the ulcer including wound bed, undermining and tunneling, exudate, surrounding skin etc. -Presence of pain	F 686		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/18/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/18/2023. At the time of this survey, Good Samaritan Society, Jackson was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 08/24/2023

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.

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GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON** **JACKSON, MN 56143**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Good Samaritan Society - Jackson is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1956, is one-story, has no basement, and was determined to be of Type I(332) construction; The 1st Addition was constructed in 1965, is one-story, has no basement, and was determined to be of Type I(332) construction; The 2nd Addition was constructed in 1976, is one-story, has a partial	K 000		

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	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/18/2023**

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K 000	Continued From page 2 basement, and was determined to be of Type I(332) construction; The 3rd Addition was constructed in 1996, is one-story, has no basement, and was determined to be of Type I(332) construction. The building is divided into six smoke compartments. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918		8/25/23

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K 918	Continued From page 3 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 emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.4, 6.5.4, 6.6.4 and NFPA 110 (2010 edition), section 8.1.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 07/18/2023 at 10:30 AM, it was revealed that a annual maintenance inspection had not occurred on the emergency generator and transfer switch in 2022. An interview with the Facilities Maintenance Director verified this deficient finding at the time of discovery.	K 918	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. K918 1. Auto transfer switch inspection and	

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K 918	Continued From page 4	K 918	load bank test completed 7/19/2023. 2. Generator did not fail so no residents were affected. 3. Re-education provided to maintenance director on timing of load bank test by administrator. 4. Maintenance director or designee will follow up with the general contractor to ensure that the load bank test is scheduled on time, before 2024. The computerized maintenance program will be updated to ensure proper timing of future testing Date of Correction – 8/25/23	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be	K 923		8/25/23

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K 923	Continued From page 5 stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect portable oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 07/18/2023 at 11:30 AM, it was revealed by observation during a walk-through of the facility that six oxygen cylinders were being stored in the closet of resident room 25. An interview with Facilities Maintenance Director verified this deficient finding at the time of discovery.	K 923	K923 1. The O2 tanks were removed from room 25 on 7/18/23. 2. Resident rooms of those using O2 were checked for storage of O2 tanks. 3. DNS will provide re-education to all nursing staff that O2 cylinders must be stored in specified O2 storage area. 4. DNS or designee will check resident rooms of those on O2 for improper storage of O2 cylinders Weekly X 4 then Monthly X 3 Results will be taken to monthly QAPI committee for further recommendations Completion date – 8-25-23	