



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 19, 2025

Administrator
Good Samaritan Society Inver Grove Heights
1301 50th Street East
Inver Grove Heights, MN 55077

RE: CCN: 245285
Cycle Start Date: April 2, 2025

Dear Administrator:

On May 15, 2025, the Minnesota Department of Health 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.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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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May 19, 2025

Administrator
Good Samaritan Society Inver Grove Heights
1301 50th Street East
Inver Grove Heights, MN 55077

Re: Reinspection Results
Event ID: OQPS12

Dear Administrator:

On May 15, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 2, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Melissa Poepping'.

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
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1301 50th Street East
Inver Grove Heights, MN 55077

RE: CCN: 245285
Cycle Start Date: April 2, 2025

Dear Administrator:

On April 2, 2025, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 July 2, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

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

Good Samaritan Society Inver Grove Heights

April 11, 2025

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488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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



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Administrator
Good Samaritan Society Inver Grove Heights
1301 50th Street East
Inver Grove Heights, MN 55077

Re: State Nursing Home Licensing Orders
Event ID: OQPS11

Dear Administrator:

The above facility was surveyed on April 1, 2025 through April 2, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

Good Samaritan Society Inver Grove Heights

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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:

LeAnn Huseh, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseh@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

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

PRINTED: 04/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/02/2025
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY INVER GROVE HEIGHTS	STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>On 4/1/25 and 4/2/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed: H52852121C (MN00111708) with deficiencies issued at F550, F677, F770, and F880.</p> <p>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.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000		
F 550 SS=D	<p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§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.</p> <p>§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</p>	F 550		5/5/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/21/2025
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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 550	<p>Continued From page 1</p> <p>individuality. The facility must protect and promote the rights of the resident.</p> <p>§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.</p> <p>§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.</p> <p>§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.</p> <p>§483.10(b)(2) The resident has the right to be 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 ensure dignity was maintained for 2 of 3 residents (R1, R2) reviewed for dignity.</p> <p>Findings include:</p> <p>R1</p> <p>R1's quarterly Minimum Data Set (MDS) dated</p>	F 550	<p>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</p>	

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F 550	<p>Continued From page 2</p> <p>2/12/25, indicated R1 was cognitively intact, and was dependent upon staff for all activities of daily living (ADLs). Identified R1 had diagnoses that included traumatic spinal cord dysfunction and quadriplegia.</p> <p>R1's care plan dated 8/26/24, indicated R1 had a self-care performance deficit related to quadriplegia and further indicated due to paralysis and contractures, R1 needed assistance with personal hygiene.</p> <p>On 4/1/25 at 1:44 p.m., during an interview and observation, R1 stated her nails were trimmed very occasionally and thought it had been weeks since they had been cut. R1 stated she preferred them short. R1's left hand was not covered by the blanket and her fingernails were very long. R1 stated she felt like staff did not want to help her or take care of her.</p> <p>On 4/2/25 at 11:48 a.m., during an observation and interview, the director of nursing (DON) observed R1's fingernails and stated the nails were too long, and should have been cut during R1's bath. The DON stated residents did not "feel great" when they did not get their care.</p> <p>R2</p> <p>R2's significant change MDS dated 1/31/25, indicated R2 was cognitively intact, had an indwelling catheter, and diagnosis of an unspecified neurological condition.</p> <p>R2's diagnoses list printed 4/2/25, indicated epilepsy, a bladder disorder, and cystitis (an inflammation of the bladder).</p>	F 550	<p>center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the State Operations Manual.</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident (R1) and Resident (R2) received showers and nail care. Resident (R2) was scheduled for a haircut and beard trim and a dignity bag was placed over the drainage bag for the indwelling foley catheter.</p> <p>2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All Residents that require assistants with ADLs have the potential to be affected by the alleged deficient practice. A review was completed to evaluate any additional residents having the potential to be affected by the alleged deficient practice and all identified residents were provided showers and nail care as needed. All Residents with indwelling foley catheters were provided with covers for drainage bags to insure dignity.</p> <p>3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained the DNS/Designee will review and educate all CNA and Nursing staff on</p>	

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F 550	<p>Continued From page 3</p> <p>R2's care plan dated 12/5/24, indicated R2 had a self-care performance deficit and required one staff for bathing and preferred baths/showers twice a week. R2's care plan lacked preferences for hair care and beard care.</p> <p>On 4/1/25 at 5:07 p.m., during an interview, nursing assistant (NA)-B stated she was not able to find documentation of R2 receiving baths in the electronic health record (EHR) in the past few weeks. NA-B stated R2 would want his showers, liked to look good, and all the residents liked to look good.</p> <p>On 4/2/25 at 9:48 a.m., during an observation and interview, R2 was sitting in the dining room with his hair uncombed and long over his ears, and a beard that appeared long and un-groomed. R2 stated it had been a couple of weeks since he had shower and had one beard trim and hair cut in the seven months he had been in the facility. R2's fingernails were long and jagged. R2 stated he needed them cut, but the activity staff who normally cut them had been gone, and no one else had cut them. R2's catheter was uncovered and in view of other residents and visitors in the dining room. R2 stated he did not look like he did when he lived at home and wanted to go home to look better again, and wished his catheter bag was covered.</p> <p>On 4/2/25 at 10:48 a.m., a message was left for R2's family member (FM)-A to return a call to the surveyor. FM-A returned the call on 4/2/25 at 5:28 p.m. During an interview, FM-A stated R2 liked his hair short, beard trimmed, and R2 paid attention to his appearance before he was admitted to the facility.</p>	F 550	<p>Sanford Policy entitled, (Resident Dignity). The facility reviewed shower schedules, verified that each was correctly entered into each Residents Care Plan to include preferences. The shower schedule and nail care were included as a weekly task. Each resident will be offered a shower and nail care in accordance with their schedule, if the resident refuses, they will be re-approached by the CNA and if they continue to refuse, the CNA will notify the Nurse of the refusal. The Nurse should explain the benefits and risks and document the outcome of the conversation. The care plans for all Residents that have indwelling foley catheters were reviewed and tasks were added to those Residents task sheets to ensure that the drainage bags are covered to provide dignity. Tasks will be documented in the EHR each shift.</p> <p>4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is sustained the DNS/Designee will conduct 5 random audits 3 times a week to visualize and interview that tasks were completed to the Residents satisfaction. Documentation of audits will be completed by the DNS/Designee for each Resident interviewed. Audits will be completed for a minimum of 5 Residents 3 times a week for no less 4 weeks, then a minimum of 2 residents once a week for no less than an additional 4 weeks, then a minimum of 2 Residents will be chosen each week until compliance is maintained consistently for an additional 4 weeks, at which time the</p>	

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F 550	Continued From page 4 FM-A stated R2 liked his nails trimmed short and if they were long, R2 would have felt unkept. FM-A stated R2 spent his life going to work in a suit every day and looked professional. Additionally, FM-A stated R2 would be embarrassed if his catheter was showing and if it was noticeable by others. FM-A stated R2 would not like it. On 4/2/25 at 11:31 a.m., during a follow-up interview, DON stated residents felt better when they received their scheduled showers and care, and without scheduled care, the residents would experience a loss of dignity. The DON further stated R2 would not like his catheter showing and would want staff to cover it. The Resident Dignity policy dated 12/11/24, indicated the interdisciplinary team would assist in maintaining the dignity of all residents by grooming residents as they wished to be groomed (hair combed and styled, beards shaved/trimmed, nails clean and clipped). The policy further indicated staff would refrain from keeping urinary bags uncovered. The Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen policy dated 7/30/24 indicated every effort is made to keep a resident's catheter covered or out of sight. Catheter bags should be covered when up in a chair and out in public or visible from door/hall. Catheter tubing is secured to the resident's leg, coiled on bed with no kinks, obstructions and the rest of the tubing should be in a straight line into urinary drainage bag.	F 550	audits may be reviewed by the QA committee for need of ongoing continuation. 5. What is the date of completion? 05/05/2025		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		5/5/25	

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F 677	<p>Continued From page 5</p> <p>§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 ensure nail care was provided for 2 of 3 residents (R1, R2) and bathing/shower assistance was provided for 2 of 3 residents (R2, R3) reviewed for activities of daily living (ADLs).</p> <p>Findings include:</p> <p>R1</p> <p>R1's quarterly Minimum Data Set (MDS) dated 2/12/25, indicated R1 was cognitively intact, and was dependent upon staff for all ADLs. Identified R1 had diagnoses that included traumatic spinal cord dysfunction and quadriplegia.</p> <p>R1's care plan dated 8/26/24, indicated R1 had a self-care performance deficit related to quadriplegia and further indicated due to paralysis and contractures, R1 needs assistance with personal hygiene.</p> <p>On 4/1/25 at 1:44 p.m., during an interview and observation, R1 stated her nails were trimmed very occasionally and thought it had been weeks since they had been cut. R1 stated she preferred them short. R1's left hand was not covered by the blanket and her fingernails were very long.</p> <p>On 4/2/25 at 10:37 a.m., during an interview nursing assistant (NA)-C stated she was unsure</p>	F 677	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident (R1) and Resident (R2) received showers and nail care. Resident (R2) was scheduled for haircut and beard trim and a dignity bag was placed over the drainage bag for the indwelling foley catheter.</p> <p>2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All Residents that require assistants with ADLs have the potential to be affected by the alleged deficient practice. A review was completed to evaluate any additional residents having the potential to be affected by the alleged deficient practice and all identified residents were provided showers and nail care as needed. All Residents with indwelling foley catheters were provided with covers for drainage bags to insure dignity.</p> <p>3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained the DNS/Designee will review and educate all CNA and Nursing staff on Sanford Policy entitled, (Resident Bathing)</p>	

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F 677	<p>Continued From page 6</p> <p>who was supposed to cut R1's nails and was unsure if the nursing assistants were supposed to and acknowledged she had not cut R1's nails.</p> <p>On 4/2/25 at 10:58 a.m., during an interview, family member (FM)-A stated R1's nails were long and needed to be cut.</p> <p>R2</p> <p>R2's significant change MDS dated 1/31/25, indicated R2 admitted to the facility 9/5/24, was cognitively intact, had an indwelling catheter, and diagnosis of an unspecified neurological condition.</p> <p>R2's diagnoses list printed 4/2/25, indicated epilepsy, a bladder disorder, and cystitis (an inflammation of the bladder).</p> <p>R2's care plan dated 12/5/24, indicated R2 had a self-care performance deficit and required one staff for bathing and preferred baths/showers twice a week. The care plan lacked preferences for hair care and beard care.</p> <p>R2's bath task log printed 4/2/25, indicated baths on Monday and Friday evening, adjusted on 4/2/25, for showers on Saturday evenings only and indicated the following bath data: 3/3/25 shower 3/7/25 NA [not applicable] 3/10/25 shower 3/14/25 NA 3/17/25 non facility staff provided care 100% of the time [for residents on hospice - R2 was not on hospice]. 3/21/25 NA</p>	F 677	<p>The facility reviewed shower schedules, verified that each was correctly entered into each Resident's Care Plan to include preferences. The shower schedule and nail care were included as a weekly task. Each resident will be offered a shower and nail care in accordance with their schedule, if the resident refuses, they will be re-approached by the CNA and if they continue to refuse the CNA will notify the Nurse of the refusal. The nurse should explain the benefits and risks and document the outcome of the conversation. The care plans for all Residents that have indwelling foley catheters were reviewed and tasks were added to the Resident's task sheets to ensure that the drainage bags are covered to provide dignity. Tasks will be documented in the EHR each shift. All Nurses and CNAs received education of the new procedure.</p> <p>4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur To ensure compliance is sustained the DNS/Designee will conduct 5 random audits 3 times a week to visualize and interview that tasks were completed to the Resident's satisfaction along with conducting a review of shower and Foley drain bag documentation in the EMR during the Clinical Morning Meeting. Audits will be completed for a minimum of 2 Residents 3 times a week for no less 4 weeks, then a minimum of 2 residents once a week for no less than an additional 4 weeks, then a minimum of 2 Residents will be chosen each week until</p>	

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F 677	<p>Continued From page 7 3/24/25 did not occur</p> <p>On 4/1/25 at 4:59 p.m., during an interview registered nurse (RN)-C acknowledged R2 had two baths in the past 30 days and stated the bath schedule did not match the printed schedule which may be why the baths were not completed.</p> <p>On 4/1/25 at 5:07 p.m., during an interview NA-B stated she could not find baths recorded for R2 in the electronic health record (EHR) in the past few weeks. NA-B stated the facility had enough staff to provide baths for residents, and the schedule was printed and posted on the nursing cart.</p> <p>On 4/2/25 at 9:48 a.m., during an observation and interview, R2 was sitting in the dining room with his hair uncombed and long over his ears, with a beard that appeared long and un-groomed. R2 stated it had been a couple of weeks since he had shower and had one beard trim and hair cut in the seven months he had been in the facility. R2's fingernails were long and jagged. R2 stated he needed them cut, but the activity staff who normally cut them had been gone, and no one else had cut them. The director of nursing (DON) approached R2 and inquired about his hair and beard preferences. R2 told the DON he preferred a monthly trim, and had only had one beard trim since he arrived. DON stated to R2 she would add his preferences to his care plan.</p> <p>On 4/2/25 at 10:15 a.m., during an interview, NA-A stated R2 had not had a shower he was aware of, but thought he was scheduled for evening showers. NA-A stated the chart indicated R2 showered on Monday and Friday evening, but was supposed to get showers on Saturday evenings. NA-A stated the data in the EHR did</p>	F 677	<p>compliance is maintained consistently for an additional 4 weeks, at which time the audits may be reviewed by the QA committee for need of ongoing continuation.</p> <p>5. What is the date of completion? 05/05/2025</p>	

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F 677	<p>Continued From page 8</p> <p>not match the schedule, and may be why the showers were not completed. NA-A further stated R2 needed his nails cut but the nursing assistants could not do it because R2 was diabetic.</p> <p>On 4/2/25 at 10:39 a.m., during an interview ,NA-D stated there was enough staff to provide baths and did not know why R2 was not getting showers weekly. NA-D acknowledged R2 did not refuse showers.</p> <p>On 4/2/25 at 10:24 a.m., during an observation, the DON observed R2's nails, acknowledged R2's nails should have been cut and asked a nurse to cut R2's nails.</p> <p>On 4/2/25 at 10:48 a.m., a message was left for R2's family member to return a call to the surveyor. FM-A returned the call on 4/2/25 at 5:28 p.m. During an interview, FM-B stated R2 liked his hair short and beard trimmed and he paid attention to his appearance before he was admitted to the facility.</p> <p>R3</p> <p>R3's Medicare 5-Day MDS dated 2/16/25, indicated R3 was unable to participate in the cognitive assessment but had a memory problem. Identified R3 was dependent in all ADLs and had diagnoses that included Multiple Sclerosis (MS).</p> <p>R3's care plan dated 10/17/23, indicated R3 had a self-care performance deficit related to MS and required assistance of staff for bathing. The care plan indicated R3 did not like showers but was</p>	F 677		

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F 677	<p>Continued From page 9</p> <p>updated on 4/2/25, to indicate R3 could use the tilt in space shower chair to take a shower.</p> <p>R3's bath task data printed 4/2/25, indicated R3 had baths on Monday evenings, Wednesday and Saturday mornings, and indicated the following bath data: 3/15/25 bed bath 3/17/25 sponge bath 3/19/25 NA 3/22/25 NA 3/24/25 NA 3/31/25 bed bath</p> <p>On 4/1/25 at 4:50 p.m., during an observation, R3 was lying in bed, her hair appeared greasy.</p> <p>On 4/2/25 at 10:39 a.m., during an interview ,NA-D stated there was enough staff to provide baths, did not know why R3 was not getting showers weekly and acknowledged R3 did not refuse showers.</p> <p>On 4/1/25 at 5:07 p.m., during an interview, NA-B stated R3 did not have her scheduled bath on 3/22/25, did not know why, and acknowledged R3 did not refuse baths. NA-B stated the NAs were supposed to tell the nurses when residents refused baths, and further acknowledged there was no documentation to indicate R3 refused any baths.</p> <p>On 4/2/25 at 11:31 a.m., during an observation and interview, the DON observed R1's fingernails and stated they were too long and would have staff cut them. The DON stated the facility had a performance improvement plan (PIP) for baths, and she had changed the bath schedules that morning (4/2/25) to be performed once weekly.</p>	F 677		

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F 677	<p>Continued From page 10</p> <p>The DON stated residents could request an extra bath, but they were no longer scheduled more than once weekly. The DON stated resident nail care was supposed to occur on bath days. Further, the DON acknowledged R2 and R3 did not receive weekly baths and did not know why. DON stated the facility had enough staff to provide weekly baths. In addition, the DON acknowledged R2's last documented shower was 3/10/25, and R3 missed three baths in March that were charted as NA and did not know why. The DON stated residents felt better when they received their scheduled showers and cares.</p> <p>On 4/2/25 at 4:15 p.m., an email sent by the administrator indicated the facility implemented a performance improvement plan (PIP) on 3/19/25, to ensure residents were showered/ bathed weekly. The email indicated there was some improvement however, acknowledged R2 and R3 were identified as not having scheduled baths on 3/29/25, and did not provide baths/showers for either resident until 4/2/25.</p> <p>On 4/3/25 at 2:20 p.m., an email sent by the administrator included documentation R2 was offered a shower and face trim after survey exit and declined.</p> <p>The Activities of Daily Living policy dated 12/4/23, indicated any resident who was unable to carry out activities of daily living would receive necessary services to maintain good grooming, personal care, and oral hygiene. The policy stipulated ADLs, were those necessary tasks conducted in the normal course of a resident's daily life. Included in these tasks were care of hair, hands, face, shaving, nails, and oral care.</p>	F 677		

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F 770 F 770 SS=D	<p>Continued From page 11</p> <p>Laboratory Services CFR(s): 483.50(a)(1)(i)</p> <p>§483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a provider order for a TSH (thyroid-stimulating hormone - a protein produced in the brain that regulates the thyroid gland's production of thyroid hormones) blood draw was performed as ordered for 1 of 3 residents (R3) reviewed for services performed as ordered.</p> <p>Findings include:</p> <p>R3's Medicare 5-Day Minimum Data Set (MDS) dated 2/16/25, indicated R3 was unable to complete the cognitive assessment, but had a memory problem. Identified a diagnosis that included a thyroid disorder.</p> <p>R3's diagnoses list printed 4/2/25, included hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone).</p> <p>R3's progress notes dated 3/19/25, at 3:28 p.m. indicated the TSH (thyroid-stimulating hormone) lab level was not drawn because the order was missing the resident's room number, and the lab would be redrawn 3/21/25. The medical record</p>	F 770 F 770	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility's Medical Director was notified that Resident (R3) had missed a TSH lab that was ordered on 03/19/2025. The TSH was rescheduled, completed and resulted within normal ranges. The Medical Provider was notified of the results.</p> <p>2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All Residents that require that lab work be completed have the potential to be affected by the alleged deficient practice. The facility reviewed each Resident's EMR for compliance related to completing labs ordered by the Provider. All ordered labs were found to be complete.</p> <p>3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur?</p>	5/5/25

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F 770	<p>Continued From page 12</p> <p>lacked indication an order was placed to redraw the lab on 3/21/25, nor that it had been performed.</p> <p>R3's provider orders printed 4/1/25, lacked an order for a TSH level to be re-drawn 3/21/25, as indicated in the progress note.</p> <p>On 4/2/25 at 11:30 a.m., during an interview, registered nurse (RN)-A stated she was new and not aware of the lab order for R3, nor the lab process, and requested the director of nursing (DON) assist with answering the questions.</p> <p>On 4/2/25 at 11:31 a.m., during an interview the DON stated the nurses were responsible to enter the lab orders, a lab technician came the facility on Wednesdays and Fridays to draw labs, and the nurses followed up with the ordering provider after lab results were reported to the facility. The DON stated she was unsure how the TSH order got missed.</p> <p>On 4/2/25 at 12:46 p.m., during an interview the nurse practitioner (NP)-A stated she ordered the TSH level, and it should have been obtained. NP-A stated R3's levothyroxine (medication used to treat hypothyroidism) dose was decreased from 124 micrograms (mcg) to 112 mcg on 2/24/25, because R3's TSH level was 10.2 [mIU/L - milli-international units per liter] on 2/21/25, with a normal range of 0.3 to 4.2 [mIU/L]. NP-A acknowledged R3's TSH was not performed as ordered but was ordered because when the previous TSH result was too high, the levothyroxine dose was adjusted. The TSH level was required to determine if further medication adjustment was required. NP-A stated if R3's TSH level was too high, R3 could experience</p>	F 770	<p>To ensure systemic changes are sustained the DNS/Designee will review and educate the Health Information Manager, (HIM) and all Nursing staff on Sanford Policy entitled, (Processing and Auditing Laboratory and Diagnostic Orders). All laboratory work ordered by the Provider will be entered into the Physician's orders as 2-steps. Step-1 (Drawn), this should be signed off in the TAR on the day that the Lab comes to collect the specimen and Step-2 (Reported), should be prompted to show up in the TAR the following day as a reminder to the Nurse that results need to be reported to the Provider.</p> <p>4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is sustained the DNS/Designee will conduct and document 5 random audits 2 times a week following scheduled Lab days. The EMR should be reviewed during the Clinical Morning Meeting for any new orders for Resident labs. Audits will be completed for a minimum of 2-3 Residents twice a week following scheduled lab days, for no less 4 weeks, then a minimum of 3 residents once a week following scheduled lab days for no less than an additional 4 weeks, then a minimum of 2 Residents will be chosen each week until compliance is maintained consistently for an additional 4 weeks, at which time the audits may be reviewed by the QA committee for need of ongoing continuation.</p> <p>5. What is the date of completion? 05/05/2025</p>	

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F 770	Continued From page 13 weight loss, loss of appetite, or feel cold. NP-A indicated R3's health was already declining and NP-A did not want to see a decline related to an elevated TSH level.	F 770		
F 880 SS=D	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include,</p>	F 880		5/5/25

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F 880	<p>Continued From page 14</p> <p>but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p>	F 880		

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F 880	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was completed for 1 of 3 residents (R1). Additionally, the facility failed to secure a leg bath for a catheter off the floor for 1 of 1 resident (R2) reviewed for infection control.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated 2/12/25, indicated R1 was cognitively intact, had an indwelling catheter, an ostomy (a surgically created opening in the abdomen that allows waste to exit the body), a feeding tube, and was dependent upon staff for all activities of daily living (ADLs). Identified R1 had diagnoses that included traumatic spinal cord dysfunction, a neurogenic bladder (loss of bladder function due to a nerve problem), and quadriplegia.</p> <p>R1's care plan dated 8/26/24, indicated R1 had an indwelling foley catheter, a feeding tube, and indicated enhanced barrier precautions (EBP) (measures intended to prevent the spread of multi-drug-resistant organisms) was in place related to wounds and an indwelling catheter.</p> <p>On 4/1/25 at 1:25 p.m., during an observation R1's door had two signs posted to indicate the following:</p> <p style="padding-left: 40px;">Enhanced Barrier Precautions (EBP) Sign 1: Families and Visitors, please follow enhanced barrier precautions. If you have questions, please see nurse. Everyone must clean their hands before entering room and when leaving the room.</p>	F 880	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident (R1) indwelling Foley drainage bag was secured off the floor with a dignity bag. RN-A received 1 on 1 reeducated related to appropriate hand hygiene.</p> <p>2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents residing in the facility have the potential to be affected by the alleged deficient practice. Facility's Infection Control tracking documentation was reviewed to identify any cluster infections potentially related to lack of staff compliance with proper hand hygiene, none were identified.</p> <p>3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained the DNS/Designee will review and educate all CNA and Nursing staff on Sanford Policy entitled, (Hand Hygiene) and (Resident Dignity). Nurses and CNAs were reeducated on the Indications of when Hand Hygiene is needed. The recommended scrub time for Soap and Water, when it is appropriate to use ABHS vs Soap and Water and the importance of compliance with adequate hand washing</p> <p>4. How will the corrective action be monitored to ensure the deficient practice</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/02/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY INVER GROVE HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
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F 880	<p>Continued From page 16</p> <p>Providers and Sign 2: Providers and Staff: Wear gloves and a gown for the following high-contact resident care activities: Bathing/ showering, transferring residents from one position to another, changing bed linens, providing hygiene (only during high contact activities such as peri-care), changing briefs or assisting with toileting, caring for assisting with an indwelling medical device (for example central venous catheter, urinary catheter, feeding tube care, tracheostomy/ventilator care) and performing wound care.</p> <p>On 4/1/25 at 2:03 p.m., during an observation, registered nurse (RN)-B entered R1's room with medications wearing gloves. While performing cares, RN-B doffed his gloves and donned clean gloves to move a graduated cylinder off R1's tray table without performing hand hygiene between glove changes. R1 asked RN-B to scratch the back of her head. RN-B doffed gloves and re-donned gloves, without performing hand hygiene between.</p> <p>On 4/1/25 at 2:24 p.m., during an interview, RN-B acknowledged he had not performed hand hygiene between gloves changes and stated he had not because he was only in the room to give medications. RN-B acknowledged he touched many items in the room and should have performed hand hygiene according to EBP.</p> <p>On 4/2/25 at 9:32 a.m., during an observation, RN-A entered R1's room to view R1's tube feeding (TF) pump. RN-A donned a gown and gloves and entered R1's room without performing</p>	F 880	<p>is being corrected and will not recur? To ensure compliance is sustained the DNS/Designee will conduct 5 random audits 3 times a week to visualize staff performance and compliance of appropriate Hand Hygiene. Documentation of audits will be completed by the DNS/Designee for each monitored staff member. Any needed correction will be immediately provided at the time audit is being completed. Audits will be completed for a minimum of 5 Staff members 3 times a week for no less 4 weeks, then a minimum of 5 staff once a week for no less than an additional 4 weeks, then a minimum of 2 staff will be randomly chosen each week until compliance is maintained consistently for an additional 4 weeks, at which time the audits may be reviewed by the QA committee for need of ongoing continuation. 5. What is the date of completion? 05/05/2025</p>	

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

PRINTED: 04/22/2025
FORM APPROVED
OMB NO. 0938-0391

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F 880	<p>Continued From page 17</p> <p>hand hygiene. RN-A stated the TF pump was not working, and RN-A doffed her gloves and gown, and left the room without performing hand hygiene. RN-A returned to the room with new tubing for the TF, donned gown and gloves and entered the room without performing hand hygiene.</p> <p>On 4/2/25 at 9:41 a.m., during an interview, RN-A acknowledged she had not performed hand hygiene during her interactions with R1 but should have when she entered and exited the room. RN-A stated she was in a rush and just did not do it. RN-A stated R1 was on contact precautions, and R1 could get an infection from staff if the precautions were not followed. RN-A looked at the precaution signs on R1's door and stated, "No, she is on Enhanced Barrier Precautions. It's the same, I think."</p> <p>R2</p> <p>R2's significant change MDS dated 1/31/25, indicated R2 was cognitively intact, had an indwelling catheter, and diagnosis of an unspecified neurological condition.</p> <p>R2's diagnoses list printed 4/2/25, indicated a bladder disorder, and cystitis (an inflammation of the bladder).</p> <p>R2's care plan dated 9/5/24, indicated R2 had a Foley catheter, and on 9/6/24, was on EBP.</p> <p>On 4/1/25 at 4:48 p.m., during an observation, R2 had EBP signs on his door.</p> <p>On 4/2/25 at 9:48 a.m., during an observation and</p>	F 880		

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F 880	<p>Continued From page 18</p> <p>interview, R2 was sitting in the dining room, his catheter leg bag was full and sitting on the floor between R2's feet, and the strap to secure the bag was also resting on the floor. R2 stated he wished the bag was strapped to his leg and further stated he did not want an infection from the bag being on the ground as he had many urinary infections before.</p> <p>On 4/2/25 at 10:15 a.m., during an interview, nursing assistant (NA)-A acknowledged R2's catheter bag was full, sitting on the floor, and the outlet tube was touching the floor. NA-A stated the floor was not a clean place for the catheter bag, and R2 could get an infection from the catheter bag and outlet sitting on the ground. NA-A secured the catheter bag to R2's leg.</p> <p>On 4/2/25 at 10:24 a.m., during an interview, the director of nursing (DON) stated R2's catheter bag should not rest on the floor to prevent infection. During a follow-up interview on 4/2/25 at 11:31 a.m., the DON stated staff were expected to perform hand hygiene prior to entering /exiting a room and in between glove changes.</p> <p>The Hand Hygiene policy dated 3/29/22, indicated hand hygiene should be performed before entering a room, before a clean task, after glove removal, and after exiting a room.</p> <p>The Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen policy dated 7/30/24, indicated catheter tubing should never be allowed to touch the floor.</p>	F 880		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY INVER GROVE H	STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>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.</p> <p>INITIAL COMMENTS: On 4/1/25 and 4/2/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/21/25
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Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>these orders and identify the date when they will be completed.</p> <p>The following complaint was reviewed: H52852121C (MN00111708) with licensing orders issued at 1390 and 1850.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of</p>	2 000		

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2 000	Continued From page 2 state form. 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.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		5/5/25

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21390	<p>Continued From page 3</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was completed for 1 of 3 residents (R1). Additionally, the facility failed to secure a leg bath for a catheter off the floor for 1 of 1 resident (R2) reviewed for infection control.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated 2/12/25, indicated R1 was cognitively intact, had an indwelling catheter, an ostomy (a surgically created opening in the abdomen that allows waste to exit the body), a feeding tube, and was dependent upon staff for all activities of daily living (ADLs). Identified R1 had diagnoses that included traumatic spinal cord dysfunction, a neurogenic bladder (loss of bladder function due to a nerve problem), and quadriplegia.</p> <p>R1's care plan dated 8/26/24, indicated R1 had an indwelling foley catheter, a feeding tube, and indicated enhanced barrier precautions (EBP) (measures intended to prevent the spread of multi-drug-resistant organisms) was in place related to wounds and an indwelling catheter.</p> <p>On 4/1/25 at 1:25 p.m., during an observation R1's door had two signs posted to indicate the following:</p> <p style="padding-left: 40px;">Enhanced Barrier Precautions (EBP) Sign 1: Families and Visitors, please follow enhanced barrier precautions. If you have questions, please see nurse. Everyone must clean their hands before entering room and when leaving the room.</p>	21390	Corrected	
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21390	<p>Continued From page 4</p> <p>Providers and Sign 2: Providers and Staff: Wear gloves and a gown for the following high-contact resident care activities: Bathing/ showering, transferring residents from one position to another, changing bed linens, providing hygiene (only during high contact activities such as peri-care), changing briefs or assisting with toileting, caring for assisting with an indwelling medical device (for example central venous catheter, urinary catheter, feeding tube care, tracheostomy/ventilator care) and performing wound care.</p> <p>On 4/1/25 at 2:03 p.m., during an observation, registered nurse (RN)-B entered R1's room with medications wearing gloves. While performing cares, RN-B doffed his gloves and donned clean gloves to move a graduated cylinder off R1's tray table without performing hand hygiene between glove changes. R1 asked RN-B to scratch the back of her head. RN-B doffed gloves and re-donned gloves, without performing hand hygiene between.</p> <p>On 4/1/25 at 2:24 p.m., during an interview, RN-B acknowledged he had not performed hand hygiene between gloves changes and stated he had not because he was only in the room to give medications. RN-B acknowledged he touched many items in the room and should have performed hand hygiene according to EBP.</p> <p>On 4/2/25 at 9:32 a.m., during an observation, RN-A entered R1's room to view R1's tube feeding (TF) pump. RN-A donned a gown and gloves and entered R1's room without performing hand hygiene. RN-A stated the TF pump was not</p>	21390		
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21390	<p>Continued From page 5</p> <p>working, and RN-A doffed her gloves and gown, and left the room without performing hand hygiene. RN-A returned to the room with new tubing for the TF, donned gown and gloves and entered the room without performing hand hygiene.</p> <p>On 4/2/25 at 9:41 a.m., during an interview, RN-A acknowledged she had not performed hand hygiene during her interactions with R1 but should have when she entered and exited the room. RN-A stated she was in a rush and just did not do it. RN-A stated R1 was on contact precautions, and R1 could get an infection from staff if the precautions were not followed. RN-A looked at the precaution signs on R1's door and stated, "No, she is on Enhanced Barrier Precautions. It's the same, I think."</p> <p>R2</p> <p>R2's significant change MDS dated 1/31/25, indicated R2 was cognitively intact, had an indwelling catheter, and diagnosis of an unspecified neurological condition.</p> <p>R2's diagnoses list printed 4/2/25, indicated a bladder disorder, and cystitis (an inflammation of the bladder).</p> <p>R2's care plan dated 9/5/24, indicated R2 had a Foley catheter, and on 9/6/24, was on EBP.</p> <p>On 4/1/25 at 4:48 p.m., during an observation, R2 had EBP signs on his door.</p> <p>On 4/2/25 at 9:48 a.m., during an observation and interview, R2 was sitting in the dining room, his catheter leg bag was full and sitting on the floor</p>	21390		

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21390	<p>Continued From page 6</p> <p>between R2's feet, and the strap to secure the bag was also resting on the floor. R2 stated he wished the bag was strapped to his leg and further stated he did not want an infection from the bag being on the ground as he had many urinary infections before.</p> <p>On 4/2/25 at 10:15 a.m., during an interview, nursing assistant (NA)-A acknowledged R2's catheter bag was full, sitting on the floor, and the outlet tube was touching the floor. NA-A stated the floor was not a clean place for the catheter bag, and R2 could get an infection from the catheter bag and outlet sitting on the ground. NA-A secured the catheter bag to R2's leg.</p> <p>On 4/2/25 at 10:24 a.m., during an interview, the director of nursing (DON) stated R2's catheter bag should not rest on the floor to prevent infection. During a follow-up interview on 4/2/25 at 11:31 a.m., the DON stated staff were expected to perform hand hygiene prior to entering /exiting a room and in between glove changes.</p> <p>The Hand Hygiene policy dated 3/29/22, indicated hand hygiene should be performed before entering a room, before a clean task, after glove removal, and after exiting a room.</p> <p>The Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen policy dated 7/30/24, indicated catheter tubing should never be allowed to touch the floor.</p> <p>SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could re-educate staff on appropriate Infection Control practices for Standard and Enhanced Barrier Precautions (EBP) to ensure proper hand</p>	21390		
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21390	Continued From page 7 hygiene. The DON or designee could perform periodic audits to ensure staff adherence, results of those audits could be taken to the Quality Assurance and Performance Improvement (QAPI) committee to determine compliance and need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac. Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 2 of 3 residents (R1, R2) reviewed for dignity.	21850	Corrected	5/5/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/02/2025
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY INVER GROVE H	STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077
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21850	<p>Continued From page 8</p> <p>Findings include:</p> <p>R1</p> <p>R1's quarterly Minimum Data Set (MDS) dated 2/12/25, indicated R1 was cognitively intact, and was dependent upon staff for all activities of daily living (ADLs). Identified R1 had diagnoses that included traumatic spinal cord dysfunction and quadriplegia.</p> <p>R1's care plan dated 8/26/24, indicated R1 had a self-care performance deficit related to quadriplegia and further indicated due to paralysis and contractures, R1 needed assistance with personal hygiene.</p> <p>On 4/1/25 at 1:44 p.m., during an interview and observation, R1 stated her nails were trimmed very occasionally and thought it had been weeks since they had been cut. R1 stated she preferred them short. R1's left hand was not covered by the blanket and her fingernails were very long. R1 stated she felt like staff did not want to help her or take care of her.</p> <p>On 4/2/25 at 11:48 a.m., during an observation and interview, the director of nursing (DON) observed R1's fingernails and stated the nails were too long, and should have been cut during R1's bath. The DON stated residents didn't "feel great" when they did not get their care.</p> <p>R2</p> <p>R2's significant change MDS dated 1/31/25, indicated R2 was cognitively intact, had an indwelling catheter, and diagnosis of an unspecified neurological condition.</p>	21850		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY INVER GROVE H	STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077
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21850	<p>Continued From page 9</p> <p>R2's diagnoses list printed 4/2/25, indicated epilepsy, a bladder disorder, and cystitis (an inflammation of the bladder).</p> <p>R2's care plan dated 12/5/24, indicated R2 had a self-care performance deficit and required one staff for bathing and preferred baths/showers twice a week. R2's care plan lacked preferences for hair care and beard care.</p> <p>On 4/1/25 at 5:07 p.m., during an interview, nursing assistant (NA)-B stated she was not able to find documentation of R2 receiving baths in the electronic health record (EHR) in the past few weeks. NA-B stated R2 would want his showers, liked to look good, and all the residents liked to look good.</p> <p>On 4/2/25 at 9:48 a.m., during an observation and interview, R2 was sitting in the dining room with his hair uncombed and long over his ears, and a beard that appeared long and un-groomed. R2 stated it had been a couple of weeks since he had shower and had one beard trim and hair cut in the seven months he had been in the facility. R2's fingernails were long and jagged. R2 stated he needed them cut, but the activity staff who normally cut them had been gone, and no one else had cut them. R2's catheter was uncovered and in view of other residents and visitors in the dining room. R2 stated he did not look like he did when he lived at home and wanted to go home to look better again, and wished his catheter bag was covered.</p> <p>On 4/2/25 at 10:48 a.m., a message was left for R2's family member (FM)-A to return a call to the surveyor. FM-A returned the call on 4/2/25 at 5:28 p.m. During an interview, FM-A stated R2 liked his hair</p>	21850		
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY INVER GROVE H	STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077
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21850	<p>Continued From page 10</p> <p>short, beard trimmed, and R2 paid attention to his appearance before he was admitted to the facility. FM-A stated R2 liked his nails trimmed short and if they were long, R2 would have felt unkept. FM-A stated R2 spent his life going to work in a suit every day and looked professional. Additionally, FM-A stated R2 would be embarrassed if his catheter was showing and if it was noticeable by others. FM-A stated R2 would not like it.</p> <p>On 4/2/25 at 11:31 a.m., during a follow-up interview, DON stated residents felt better when they received their scheduled showers and care, and without scheduled care, the residents would experience a loss of dignity. The DON further stated R2 would not like his catheter showing and would have staff cover it.</p> <p>The Resident Dignity policy dated 12/11/24, indicated the interdisciplinary team would assist in maintaining the dignity of all residents by grooming residents as they wished to be groomed (hair combed and styled, beards shaved/trimmed, nails clean and clipped). The policy further indicated staff would refrain from keeping urinary bags uncovered.</p> <p>The Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen policy dated 7/30/24 indicated every effort is made to keep a resident's catheter covered or out of sight. Catheter bags should be covered when up in a chair and out in public or visible from door/hall. Catheter tubing is secured to the resident's leg, coiled on bed with no kinks, obstructions and the rest of the tubing should be in a straight line into urinary drainage bag.</p> <p>SUGGESTED METHOD OF CORRECTION:</p>	21850		

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21850	<p>Continued From page 11</p> <p>The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure dignity is maintained with all residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21850		