Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 1, 2025

Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

RE: CCN: 245317
Cycle Start Date: March 6, 2025

Dear Administrator:

On April 16, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 1, 2025

Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

Re: Reinspection Results
Event ID: I5JP12

Dear Administrator:

On April 16, 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 March 6, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 21, 2025

Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

RE: CCN: 245317
Cycle Start Date: March 6, 2025

Dear Administrator:

On March 6, 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 June 6, 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 September 6, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(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
F 000	INITIAL COMMENTS On 2/27/25, 2/28/25, 3/4/25, 3/5/25 and 3/6/25, 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. The following complaint was reviewed H53178621C(MN00111001) and H53178821C (MN00110931) with deficiencies cited at F689. F684, and F880. 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 regulations has been attained.	F 000		
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:	F 684		4/10/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/31/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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
F 684	Continued From page 1 Based on observation, interview, and record review the facility failed to comprehensively assess, monitor, and implement interventions for 1 of 1 (R1) resident following a fall. Findings include: R1's face sheet dated 3/5/25, identified an admission date of 1/20/25 and diagnoses of obesity (a condition of having too much body fat), diabetes mellitus (a condition that affects how the body uses sugar as fuel), and heart failure (condition in which heart doesn't pump blood as well as it should). R1's admission Minimum Data Set (MDS) dated 1/26/25, identified R1 was cognitively intact and dependent for transfers. R1's activities of daily living (ADL) focus care plan dated 1/21/25, identified R1 was assist of two using total mechanical lift for bed mobility and assist of two with sit to stand mechanical lift for toilet use. ADL care plan revised on 1/27/25 to transfer between surfaces: stand pivot transfers with front wheeled walker from edge of bed to wheelchair with contact guard assist of one staff. The care did not identify specifically when to use the sit-to-stand vs full body mechanical lift for safe transfers. Review of R1's incident report on 2/4/25 at 10:30 p.m., identified nursing description: nursing assistant went into resident room and found resident on the floor on the side of the bed. Assisted of two with total mechanical lift into wheelchair. Stated resident refused vital signs, skin assessment, range of motion and neurologic exam. Incident report identified R1's provider	F 684	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. 1. All falls and fall-related care plan interventions for R1 were reviewed and updated to ensure they remain appropriate. R1□s care plan was updated to reflect the correct type of mechanical lift. R1 discharged home on 3/31/25. 2. All residents identified as high fall risk have the potential to be impacted. A comprehensive review of care-planned fall interventions for each of these residents was completed to ensure the interventions remain appropriate and effective. The Sit-Stand-Walk UDA was completed for all residents who require mechanical lifts to ensure the appropriate lift type was accurately documented. Additionally, care plans for these residents were reviewed and updated to reflect the specific mechanical lift used. 3. To ensure systemic changes are sustained, all nurses received education on the facility□s Fall Prevention and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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

F 684 Continued From page 2
was not notified of fall until 11:53 p.m.

Review of R1's progress notes on 2/4/25, did not identify that a fall had occurred on 2/4/25 at 10:30 p.m., nor any education provided to resident about the risks of not allowing vitals, range of motion (ROM), or neurological exam or provider notification of the refusal. Additionally did not identify a mobility assessment for safe transfers after a fall.

During an interview on 3/6/25 at 10:29 a.m., R1 stated since her fall on 2/4/25 where she fractured her clavicle, she has had pain and feel like this has made her go "backwards". R1 stated she was supposed to return to the assisted living the week she fell and now she is not able to return until she is able to do things for herself and is using the total mechanical lift now.

During an interview on 2/28/25 at 1:40 p.m., licensed practical nurse (LPN)-A stated she completed the incident report for a fall that occurred on 2/4/25 at 10:30 p.m., that was reported to her. LPN-A did not observe R1 on the floor nor perform a comprehensive assessment after the fall.

During an interview on 2/28/25 at 4:23 p.m., nursing assistant (NA)-B stated prior to the fall on 2/4/25 at 10:30 p.m., R1 was sleeping in her wheelchair and he assisted her bed and she appeared weak and was having difficulty with the transfers. NA-B had R1 sit on the edge of the bed and left the room to retrieve the sit to stand mechanical lift to transfer her to the bathroom and when he returned R1 was seated on the floor near her bed. He stated he informed licensed practical nurse (LPN)-C of the fall, and she

F 684

Management policy which includes identifying causal factors, implementing interventions, and giving prompt treatment after a fall occurs. The facility□s falls checklist was updated accordingly.
4. The Quality Assurance Coordinator or their designee will conduct audits on residents who have experienced falls, weekly x 4 weeks and then monthly x 2 months, to ensure falls are thoroughly assessed, monitored, and that appropriate interventions are implemented.
5. 4/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(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
F 684	Continued From page 3 entered the room, but unsure if she assessed R1 prior to getting her off the floor. During a follow up interview on 3/5/25 at 11:19 a.m., NA-B stated he did not inform the nurse that R1 was weak prior to attempting a transfer before the first fall at 10:30 p.m., he also stated, "I should have told the nurse she was weak before she fell at 10:30 p.m., but did not do this." During an interview on 3/4/25 at 2:37 p.m., LPN-C stated she was informed by NA-B that R1's fall on 2/4/25 at 10:30 p.m. and when she entered R1's room she was on the floor. LPN-C stated she did not perform any assessments because R1 would not allow assessments following the fall and did not document the refusals of assessments. LPN-C instructed staff to use the mechanical lift to get her in her wheelchair and she was not present in the room when staff transferred her off the floor. LPN-C stated, "I am not sure why I would have not done an assessment." She stated normal practice in the facility if the nurse is informed of a fall to do vital signs, ROM, and neurological exam before the nursing assistants can transfer a person off the floor. During an interview on 3/4/25, registered nurse (RN)-B stated if a nurse finds a resident had fallen, they will assess the resident, perform range of motion, and if unwitnessed do neurological exam. If a resident refuses this assessment, the nurse should provide education to that resident, and notify the provider. During an interview on 3/4/25, at 11:23 a.m. interim director nursing (IDON) stated the nurse should have assessed R1 her before getting her	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(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
F 684	Continued From page 4 off the floor. During an interview on 3/5/25 at 11:40 a.m., medical doctor (MD) stated her expectation would be that nursing should perform an assessment on any resident following a fall, paying close attention to range of motion and vitals. If a resident refused a comprehensive assessment, she would expect the provider to be notified of such refusal. Review of the facility's Fall Prevention and Management policy dated 7/29/24, identified procedure for a fallen resident: -Do not move resident. -A nurse must observe the resident and perform a full-body exam to determine if there may be suspected injury and direct whether to move the resident. -Obtain blood pressure, pulse, respiratory rate, pulse oximetry and temperature. Check blood sugar if resident is symptomatic of blood glucose issues. -If the fall was not witnessed, neurological checks are required and must be documented in the medical record. -Continue to monitor the resident's condition; communicate updates as needed. -Review resident's medications for recent changes or medication that could contribute to a fall. -If teaching is done, it must be documented in the medical record. -Review and update care plan with any changes/new interventions.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		4/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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
F 689	Continued From page 5	F 689		

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review the facility failed to comprehensively assess each fall, identify causal factors to determine the reason for fall, identify appropriate individualized interventions to prevent or decrease the risk of future falls for 2 of 3 residents (R1 and R5) reviewed for falls.

Findings include:

R1's face sheet dated 3/5/25, identified an admission date of 1/20/25 and diagnoses of obesity (a condition of having too much body fat), diabetes mellitus (a condition that affects how the body uses sugar as fuel), and heart failure (condition in which heart doesn't pump blood as well as it should).

R1's admission Minimum Data Set (MDS) dated 1/26/25, indicated R1 was cognitively intact and dependent for transfers and toileting. Always continent of bladder and frequently incontinent of bowel. R1's MDS indicated she had falls in the last two to six months prior to admission.

R1's activities of daily living (ADL) focus care plan dated 1/21/25, identified R1 was assist of two using total mechanical lift for bed mobility and assist of two with sit to stand mechanical lift for

Provider's Plan of Correction:

F689 Free of Accident Hazards/Supervision/Devices
1. R5 discharged from the facility on 3/10/25. All falls and fall-related care plan interventions for R1 were reviewed and updated to ensure they remain appropriate. R1 discharged home on 3/31/25.
2. All residents who have experienced a fall have the potential to be affected. Falls occurring within the last 60 days for current residents were reviewed to ensure causal factors for each incident were identified and that appropriate interventions were implemented.
3. To ensure systemic changes are sustained, all nurses received education on the facility□s Fall Prevention and Management policy which includes identifying causal factors, implementing interventions, and providing prompt treatment after a fall occurs, and the facility□s falls checklist was updated accordingly.
4. The Quality Assurance Coordinator or their designee will conduct audits on residents who have experienced falls weekly x 4 weeks and then monthly x 2 months, to ensure falls are thoroughly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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
F 689	Continued From page 6 toilet use. R1's care plan dated 1/21/25 did not address a bowel/bladder focus that would identify R1's individualized toileting plan/schedule. ADL care plan revised on 1/27/25 to transfer between surfaces: stand pivot transfers with front wheeled walker from edge of bed to wheelchair with contact guard assist of one staff. R1's fall focus care plan initiated on 1/21/25, identified at risk for fall related to (left blank). Goal to be free from falls. Interventions included ensure that resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. R1's admission fall risk assessment dated 1/21/25, identified low risk for fall. R1's fall risk assessments dated 1/27/25, 2/1/25, and 2/9/25, identified low risk for falls. R1's fall risk assessment dated 2/23/25, completed due to fall, identified medium risk for falls. R1's fall risk assessment dated 2/26/25, identified high risk for falls. Review of facility's incident report log on 2/27/25, identified R1 had seven falls between 1/23/25 and 2/26/25. R1 had an additional fall on 3/4/25. R1's incident report on 1/23/25 at 11:55 p.m., identified R1 was found seated on the floor and slipped from bed. R1 had pain in her inner part of her right leg, but no signs of evidence of concerns. No open skin areas or redness. Immediate action taken: was assisted to bed with total mechanical lift, vital signs and neurological	F 689	assessed, monitored, and that appropriate interventions are implemented. 5. 4/10/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(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
F 689	Continued From page 7	F 689		

exams began. New intervention to remind R1 to use call light for assistance with sitting on edge of bed. Facility investigation form undated, identified cause of incident was that R1 self-transferred from laying to sitting on edge of bed without assistance. Slippery nightgown was felt to be cause of R1 slipping from edge of bed, however, there was no indication interventions were developed and implemented to decrease falls related to R1's slippery night gown. R1's care plan was updated on 1/24/25 educate R1 to use call light for assistance with sitting on the edge of bed.

R1's incident report on 1/27/25 at 2:30 a.m., identified R1 was found on the floor. Door was closed, and call light not turned on. Call light was within reach. R1 was attempting to get up and go to the bathroom by herself. The incident report did not identify if R1 was incontinent or continent. Immediate action taken was assisted off the floor to the bed. Once in bed, R1 was transferred to the bathroom. New intervention added to keep door partially open. Facility investigation form undated, identified causal factor as R1 self-transferred to edge of bed without calling staff for assistance. There was no indication the investigation included an assessment to determine if R1's toileting needs were met prior to the fall and/or if R1's toileting care plan was appropriate.

R1's care plan was revised on 1/27/25 with the addition of keep door partially open.

R1's incident report dated 2/1/25 at 3:00 a.m., identified R1 was found sitting on the floor, resting her back near her bed. R1's bed in lowest position and call light within reach. R1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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

F 689 Continued From page 8 F 689

assisted to go to the bathroom around midnight. R1 stated she was trying to go to the bathroom. Immediate interventions taken was assisted back to bed with mechanical lift. New intervention: colorful signs put in room to friendly remind/encourage resident to use call light and wait for assistance with all transfers. Facility investigation form dated 2/4/25, identified cause of fall as self-transfer attempt by resident. This is the third fall from the edge of bed due to self-transfers. Facility form did not identify R1's needs to use the bathroom prior to the fall. Facility form was unsigned by director of nursing, administrator, social worker, and medical director.

R1's incident report dated 2/4/25 at 10:30 p.m., identified R1 was found on the floor on the side of the bed. Immediate action taken was assist of two with total mechanical lift into wheelchair. R1 refused vital signs, skin assessment, range of motion, and neurological exam. Facility investigation form undated, identified cause of fall that R1 often sits self-up on the edge of the bed and then slips from bed to the floor. Although the report identified she slips off the edge of the bed, there was nothing implemented to prevent this from reoccurring.

R1's incident report dated 2/4/25 at 10:41 p.m., identified R1 was in her wheelchair and two nursing assistants assisted R1 to the bathroom by sit to stand mechanical lift. R1 was not standing, and left arm went up and slid out of sling, while she kept hanging on with right arm, being two inches off the ground and landed her bottom on the bathroom floor. R1 had pain in right shoulder. Immediate action taken was ambulance called for transport to hospital. Facility investigation form undated, identified cause of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(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
F 689	Continued From page 9 incident that R1 let go of sit to stand mechanical lift with left hand leaving all her weight on the right arm. R1 heard a "pop" and was lowered to the ground. R1's progress note dated 2/5/25 at 12:06 a.m., identified R1 left facility via ambulance at 11:20 p.m. R1's progress note dated 2/5/25 at 2:10 a.m., identified R1 returned from emergency department (ED) with diagnosis of fracture of clavicle closed initial right. Review of hospital medical records dated 2/5/25, identified R1 was seen in ED due to pain in right shoulder after a fall and imaging showed an acute mildly displaced fracture of the right mid clavicle. R1 to wear sling on right arm and non-weight bearing for six weeks. R1's incident report dated 2/26/25 at 1:54 a.m., identified R1 was found sitting on the floor by the doorway in her room. R1 stated she slid out of bed after attempting to adjust herself in bed. Immediate action taken was vital signs, range of motion, neurological exam, and skin observation. Assisted back to bed with total mechanical lift. Intervention: colorful signs put in room to friendly remind/encourage resident to please use call light when needs assistance-we are here to help you. Although the analysis identified root cause of sliding out of bed there was no indication R1's care plan was revised to address the causal factors. R1's care plan previously amended on 2/1/25 for colorful signs put in room to friendly/encourage resident to please use call light and wait for staff assistance/help with all transfers.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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
F 689	Continued From page 10 R1's incident report dated 3/4/25 at 2:32 a.m., identified R1 was found on the floor with back scratcher in hands. Resident stated, "I slid out of bed, same as always, went on the floor on my buttocks." Immediate action taken was vital signs, neurological check, skin observation, range of motion. Assisted back to bed via total mechanical lift. Facility investigation form dated 3/4/25, identified cause of fall stated she fell asleep while sitting on the edge of bed. New intervention added to care plan of one-hour checks while in bed. Although the incident report identified causal factor of sliding out of bed per R1 there was no indication R1's care plan was revised to include an intervention for sliding out of bed. During an interview on 2/28/25 at 4:23 p.m., nursing assistant (NA)-B stated prior to the fall on 2/4/25, shortly before 10:30 p.m., NA-B went into R1's room to find her sleeping in her wheelchair. NA-B pushed R1 next to her bed to complete a stand pivot transfer. However, during the transfer to the edge of the bed R1 seemed really weak and had difficulty standing. R1 stated she had to go to the bathroom so NA-B left the room to get the sit-to-stand mechanical lift because R1 was having too much difficulty with standing. NA-B explained staff could use mechanical lifts when residents suddenly became unable to complete transfers. This was also care planned for R1. When NA-B returned to the room R1 was seated on the floor next to her bed. NA-B stated trained medication aide (TMA)-A and himself assisted R1 from the floor using a full body mechanical lift and placed R1 in her wheelchair. LPN-C was not in the room during the transfer. NA-B indicated once R1 was in her wheelchair she requested to use the bathroom. TMA-A and NA-B used a sit-to-stand mechanical lift to transfer R1 from the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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
F 689	Continued From page 11	F 689		

wheelchair to the toilet. They raised R1 up in the lift, pushed her towards the bathroom, and as they were turning toward the toilet, R1 became weak in the legs and began hanging in the lift after letting go with her left hand and was hanging on to the lift bar with her right hand. R1 then reported she had pain then she heard a "pop" at which point she let go with her right arm. NA-B stated we then lowered R1 to the ground. NA-B informed LPN-C of the R1's fall and she came into R1's bathroom. R1 was then sent to the hospital. During a follow up interview on 3/5/25 at 11:19 a.m., NA-B stated he did not inform the LPN-C that R1 was weak and unable to stand prior to the fall from side of the bed at 10:30 p.m. NA-B stated, "I should have told the nurse she was weak before she fell at 10:30 p.m., but did not do this."

During an interview on 3/4/25 at 2:37 p.m., LPN-C stated she was informed by NA-B of R1's fall on 2/4/25 at 10:30 p.m., When LPN-C entered R1's room R1 was seated on the floor next to her bed. LPN-C instructed staff to use the total mechanical lift to transfer her from the floor to her wheelchair.

During an interview on 3/4/25 at 11:45 a.m., interim director of nursing (IDON) stated R1's falls were not investigated thoroughly to determine if R1's basic needs were met such as toileting and indicated the cause of R1's falls on 1/27/25, 2/1/25 and 2/4/25 was that she was attempting to go to the bathroom each time and that a toileting plan should have been added at that time due to R1 being dependent on staff with toileting.

During an interview on 3/6/25 at 10:29 a.m., R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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
F 689	Continued From page 12	F 689		

stated since her fall on 2/4/25, where she fractured her right clavicle, and has gone "backwards". R1 stated she was supposed to return to the assisted living now she was not able to return until she was able to do things for herself and was using the total mechanical lift now for all transfers.

R5's face sheet dated 3/5/25, identified diagnoses of fracture of left lower leg (broken bone in leg), Alzheimer's disease (progressive disease the destroys memory), history of falling, and bipolar disorder (disorder with episodes of mood swings).

R5's admission MDS dated 2/3/25, identified R5 had severe cognitive impairment and dependent for transfers and had 1 fall since admission without injury.

R5's ADL focus care plan dated 1/28/25, identified self-care deficit related to Alzheimer's disease and recent falls at home. Goal to improve current level of functioning. Interventions dated 1/28/25 identified for toilet use assist of two with total mechanical lift. Revised on 2/28/25 to use assist of one and gait belt. Transfer assist of one and gait belt stand pivot (please use total mechanical lift as needed to transfer into bed or wheelchair) not putting weight on left lower extremity.

R5's fall focus care plan dated 1/28/25, identified R5 is at risk for falls due to history of falls, weakness, and unsteady gait/balance. Goal will be free from falls. No interventions identified.

R5's focus care plan dated 1/29/25, identified R5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(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
F 689	Continued From page 13	F 689		

had impaired cognition. Goal will be able to communicate basic needs on daily basis. Interventions were to check on frequently due to self-transfer attempts for safety and to help potentially reduce falls.

Fall Risk Assessments completed on 2/8/25, 2/11/25, and 2/15/25, identified R5 was at high-risk for falls. Falls tool action plan not marked as initiated. No fall risk assessment was provided on admission.

Review of Facility's incident report log on 2/27/25, identified R5 had five falls between 1/29/25 to 2/22/25. R1 had two additional falls on 3/1/25 and 3/4/25.

The falls are identified as follows:
R5's incident report dated 1/29/25, identified a fall at 4:20 a.m., R5 was found seated on the floor with her back resting on the side of the bed. Bed was in lowest position and call light within reach. Immediate action taken was a fall mat placed on side of bed. Care plan intervention initiated on 1/29/25 with fall mat placed next to bed and frequent check due to self-transfer attempts for safety to help potentially reduce falls.

R5's incident report dated 2/11/25, identified a fall at 7:45 p.m., R5 was in doorway of room. Immediate action taken was to remind resident on importance of using the call light when needing assistance and to not self-transfer. R5's fall record did not include a comprehensive analysis of fall nor identify possible root cause. R5's care plan revised on 2/11/25 to remind frequently to not self-transfer.

R5's incident report dated 2/15/25/25, identified a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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
F 689	Continued From page 14 fall at 4:02 p.m., R5 was found on the floor in her room seated on her knees. Immediate action taken was assisted off the floor, vital signs, taken to the bathroom, and then placed in wheelchair. Facility fall investigation form dated 2/15/25, identified cause of incident was resident yelling for help, she was leaving her room to find help, and the care plan was amended to remind resident to put on the call light and a sign was put on her table. R5's incident report dated 2/18/25 at 8:50 p.m., identified a fall when R5 was found scooting out of her room on her bottom. Immediate action taken was a skin assessment, vital signs, and range of motion. R5 was assisted by two staff using the total mechanical lift to bed. Facility investigation form dated 2/19/25, did not include a comprehensive fall analysis however identified causal factor of fall as resident was scooting on buttocks out of her room and she stated she was going to the movies. The care plan amended: if awake in room, encourage to come to commons area for better supervision. R5's care plan intervention revision on 2/19/25 if awake in bed, encourage to get up in wheelchair and come out of room into commons area for better supervision. R5's incident report dated 2/22/25 at 12:00 a.m., identified R5 was found scooting on buttocks on the floor near her doorway. R5's fall record did not include a comprehensive analysis of the fall nor identify root cause and it was not evident R5's care plan was revised. R5's incident report dated 3/1/25 at 9:45 p.m., identified R5 was found on floor scooting self on floor in the direction of the bathroom. Immediate	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(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
F 689	Continued From page 15 action taken was vital signs, neurological exam, range of motion, and skin observation. R1 was incontinent of urine. Assisted by two staff with total mechanical lift to bed. Intervention added colorful signs placed in room reminding resident to use call light for help. R5's care plan revised on 3/2/25, to place colorful signs placed in room to remind resident to call for help. R5's fall record did not include a comprehensive analysis of the fall that included and addressed R5's toileting needs. R5's incident report dated 3/3/25 at 9:15 pm., identified R5 was found lying on the floor. Immediate action taken was vital signs, neurological exam, body exam, range of motion. Assisted with two staff back to bed with total mechanical lift. Intervention of soft touch call light put in place. R5's care plan updated on 3/4/25 to soft touch call light put in place. R5's fall record did not include a comprehensive fall analysis nor identify potential root cause. During an interview on 3/6/25 at 1:03 p.m., IDON stated R5's care plan interventions to remind to use the call light/signs would not be appropriate with her cognition. IDON further stated the falls for R1 and R5, a thorough investigation was not performed to determine if basic needs were met and to determine a root cause. "We tried to put interventions in place, but they are not always related to the root cause and should have been." DON also stated when the interdisciplinary team meets each week to discuss falls, we should be adding a summary in the resident's chart, but this has not happened lately. The care plan should be updated timely with any changes of new interventions/changes so staff are aware.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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
F 689	Continued From page 16 Review of the facility's Fall Prevention and Management policy dated 7/29/24, identified procedure for a fallen resident: -Do not move resident. -A nurse must observe the resident and perform a full-body exam to determine if there may be suspected injury and direct whether to move the resident. -Obtain blood pressure, pulse, respiratory rate, pulse oximetry and temperature. Check blood sugar if resident is symptomatic of blood glucose issues. -If the fall was not witnessed, neurological checks are required and must be documented in the medical record. -Continue to monitor the resident's condition; communicate updates as needed. -Review resident's medications for recent changes or medication that could contribute to a fall. -If teaching is done, it must be documented in the medical record. -Review and update care plan with any changes/new interventions. Review of facility's Care Plan Policy dated 12/2/24, identified the care plan will be modified to reflect the care currently required/provided for the resident.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		4/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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
F 880	Continued From page 17 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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

F 880 Continued From page 18

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP-where gown and gloves used for high contact resident care activities) was used for 1 of 3 residents(R3) observed for EBP. In addition, the facility failed to ensure handwashing/hand hygiene was implemented for 2 of 7 residents (R6, R7) observed for handwashing/hand hygiene.

Findings include

R3's face sheet dated 3/6/25, identified heart failure (condition in which heart does not pump blood as well as it should), and calculus of bile duct (bile duct stones).

F 880

F880 Infection Prevention & Control
1. For R3, who required enhanced barrier precautions, appropriate signage was placed outside the resident's room, and staff were re-educated on implementing EBP per policy. For R6 and R7, staff were re-educated on proper hand hygiene practices.
2. All residents have the potential to be affected. Residents requiring enhanced barrier precautions were reviewed to ensure these precautions were included in their care plans and that appropriate signage was posted outside their doors to alert staff.
3. To ensure systemic changes are sustained, all nursing staff will receive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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
F 880	Continued From page 19 R3's care plan focus dated 4/16/24, identified enhanced barrier precautions indicated due to indwelling medical device (biliary drainage tube). Interventions to use gown and gloves when performing high contact activities (dressing, transferring, providing hygiene, repositioning, device care or wound care). During an observation on 2/27/25, at 11:15 am, R3 was in her room where nursing assistants (NA)-A and NA-C placed socks and pants on R3 with dressing, then applied a lift sling under her while turning her side to side. NA-A and NA-C then performed a transfer. NA-A and NA-C did not wear gown or gloves during cares or during the transfer. During an interview on 2/28/25 at 9:21 a.m., NA-A stated gown and gloves should be worn when performing any close contact care for any resident that is on EBP. R7's face sheet dated 3/5/25, identified diabetes mellitus (condition that affects how the body uses sugar as fuel), heart failure, and absence of left leg below knee. During an observation on 3/4/25 at 9:12 a.m., R7 was in bathroom seated on the toilet, NA-D applied gloves, however, did not perform hand hygiene before applying. NA-D then instructed R7 to stand and cleansed her perineal area (region located between the anus and genitals), NA-D then adjusted R7's clothing and adjusted R7's oxygen tubing on her face. NA-D did not remove gloves or perform hand hygiene after perineal cares. R6's face sheet dated 3/6/25, identified diabetes	F 880	reeducation on the facility□s policy Hand Hygiene and Standard and Transmission Based Precautions. 4. The Quality Assurance Coordinator or designee will conduct audits on residents R3, R6, R7, and three additional residents weekly x 4 weeks and then monthly x 2 months to ensure enhanced barrier precautions are being followed and proper hand hygiene is being performed. 5. 4/4/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(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
F 880	Continued From page 20 mellitus and kidney disease (condition where kidneys have been damaged). During an observation and interview on 3/4/25 at 9:30 a.m., R6 was seated on the toilet in the bathroom, NA-D entered R6's room and applied gloves. NA-D did not perform hand hygiene prior to applying gloves. NA-D washed R6's back and cleansed her perineal area. NA-D removed gloves and applied a new pair of gloves. Hand hygiene/handwashing was not performed prior to applying new gloves. NA-D assisted R6 with a transfer to her wheelchair, then opened up R6's drawer and removed a shirt and placed it on R6's upper body. NA-D then took R6's drinking cup and left room to fill in the facility kitchenette, however, did not remove gloves or perform hand hygiene. NA-D stated hand hygiene should be done before and after entering a resident's room, before and after cares, before touching drinkware, and before and after removal of gloves. During an interview on 3/4/25 at 12:33 p.m., director of nursing (DON) stated her expectation for staff to use EBP (gown and gloves) for any personal cares for a resident identified on these precautions and to perform handwashing/hand hygiene before and after leaving a room, before and after cares, after removal of gloves. Review of the facility's Standard and Transmission Based Precautions dated 4/2/24, identified that enhanced barrier precautions (gown and gloves) needed during high-contact resident care activities for residents with chronic wounds, indwelling medical devices (central lines, urinary catheter, feeding tubes and tracheostomies).	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE** **AUSTIN, MN 55912**

(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
F 880	Continued From page 21 Review of the facility's Hand Hygiene policy dated 3/29/22, identified all employees in patient care areas will adhere to the 4 Moments of Hand Hygiene. 1. Entering room. 2. Before clean task 3. After bodily fluid/glove removal 4. Exiting room	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 21, 2025

Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

Re: State Nursing Home Licensing Orders
Event ID: I5JP11

Dear Administrator:

The above facility was surveyed on February 26, 2025, through March 6, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 2/27/25, 2/28/25, 3/4/25, 3/5/25, 3/6/25 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 orders were issued. Please indicate in your electronic plan of correction you

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1	2 000		

have reviewed these orders and identify the date when they will be completed.

The following complaints were reviewed: H53178621C (MN00111001) and H53178821C (MN00110931) with a licensing order 0830 and 1390.

Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess each fall, identify causal factors to determine the reason for fall, identify appropriate individualized interventions to prevent or decrease the risk of future falls for 2 of 3 residents (R1 and R5) reviewed for falls. Findings include:	2 830	Acknowledged.	4/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 R1's face sheet dated 3/5/25, identified an admission date of 1/20/25 and diagnoses of obesity (a condition of having too much body fat), diabetes mellitus (a condition that affects how the body uses sugar as fuel), and heart failure (condition in which heart doesn't pump blood as well as it should). R1's admission Minimum Data Set (MDS) dated 1/26/25, indicated R1 was cognitively intact and dependent for transfers and toileting. Always continent of bladder and frequently incontinent of bowel. R1's MDS indicated she had falls in the last two to six months prior to admission. R1's activities of daily living (ADL) focus care plan dated 1/21/25, identified R1 was assist of two using total mechanical lift for bed mobility and assist of two with sit to stand mechanical lift for toilet use. R1's care plan dated 1/21/25 did not address a bowel/bladder focus that would identify R1's individualized toileting plan/schedule. ADL care plan revised on 1/27/25 to transfer between surfaces: stand pivot transfers with front wheeled walker from edge of bed to wheelchair with contact guard assist of one staff. R1's fall focus care plan initiated on 1/21/25, identified at risk for fall related to (left blank). Goal to be free from falls. Interventions included ensure that resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. R1's admission fall risk assessment dated 1/21/25, identified low risk for fall. R1's fall risk assessments dated 1/27/25, 2/1/25, and 2/9/25, identified low risk for falls.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4 R1's fall risk assessment dated 2/23/25, completed due to fall, identified medium risk for falls. R1's fall risk assessment dated 2/26/25, identified high risk for falls. Review of facility's incident report log on 2/27/25, identified R1 had seven falls between 1/23/25 and 2/26/25. R1 had an additional fall on 3/4/25. R1's incident report on 1/23/25 at 11:55 p.m., identified R1 was found seated on the floor and slipped from bed. R1 had pain in her inner part of her right leg, but no signs of evidence of concerns. No open skin areas or redness. Immediate action taken: was assisted to bed with total mechanical lift, vital signs and neurological exams began. New intervention to remind R1 to use call light for assistance with sitting on edge of bed. Facility investigation form undated, identified cause of incident was that R1 self-transferred from laying to sitting on edge of bed without assistance. Slippery nightgown was felt to be cause of R1 slipping from edge of bed, however, there was no indication interventions were developed and implemented to decrease falls related to R1's slippery night gown. R1's care plan was updated on 1/24/25 educate R1 to use call light for assistance with sitting on the edge of bed. R1's incident report on 1/27/25 at 2:30 a.m., identified R1 was found on the floor. Door was closed, and call light not turned on. Call light was within reach. R1 was attempting to get up and go to the bathroom by herself. The incident report did not identify if R1 was incontinent or continent. Immediate action taken was assisted off the floor	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ____ B. WING ____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 to the bed. Once in bed, R1 was transferred to the bathroom. New intervention added to keep door partially open. Facility investigation form undated, identified causal factor as R1 self-transferred to edge of bed without calling staff for assistance. There was no indication the investigation included an assessment to determine if R1's toileting needs were met prior to the fall and/or if R1's toileting care plan was appropriate. R1's care plan was revised on 1/27/25 with the addition of keep door partially open. R1's incident report dated 2/1/25 at 3:00 a.m., identified R1 was found sitting on the floor, resting her back near her bed. R1's bed in lowest position and call light within reach. R1 was assisted to go to the bathroom around midnight. R1 stated she was trying to go to the bathroom. Immediate interventions taken was assisted back to bed with mechanical lift. New intervention: colorful signs put in room to friendly remind/encourage resident to use call light and wait for assistance with all transfers. Facility investigation form dated 2/4/25, identified cause of fall as self-transfer attempt by resident. This is the third fall from the edge of bed due to self-transfers. Facility form did not identify R1's needs to use the bathroom prior to the fall. Facility form was unsigned by director of nursing, administrator, social worker, and medical director. R1's incident report dated 2/4/25 at 10:30 p.m., identified R1 was found on the floor on the side of the bed. Immediate action taken was assist of two with total mechanical lift into wheelchair. R1 refused vital signs, skin assessment, range of motion, and neurological exam. Facility investigation form undated, identified cause of fall	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6	2 830		

Continued From page 6

that R1 often sits self-up on the edge of the bed and then slips from bed to the floor. Although the report identified she slips off the edge of the bed, there was nothing implemented to prevent this from reoccurring.

R1's incident report dated 2/4/25 at 10:41 p.m., identified R1 was in her wheelchair and two nursing assistants assisted R1 to the bathroom by sit to stand mechanical lift. R1 was not standing, and left arm went up and slid out of sling, while she kept hanging on with right arm, being two inches off the ground and landed her bottom on the bathroom floor. R1 had pain in right shoulder. Immediate action taken was ambulance called for transport to hospital. Facility investigation form undated, identified cause of incident that R1 let go of sit to stand mechanical lift with left hand leaving all her weight on the right arm. R1 heard a "pop" and was lowered to the ground.

R1's progress note dated 2/5/25 at 12:06 a.m., identified R1 left facility via ambulance at 11:20 p.m.
R1's progress note dated 2/5/25 at 2:10 a.m., identified R1 returned from emergency department (ED) with diagnosis of fracture of clavicle closed initial right.

Review of hospital medical records dated 2/5/25, identified R1 was seen in ED due to pain in right shoulder after a fall and imaging showed an acute mildly displaced fracture of the right mid clavicle. R1 to wear sling on right arm and non-weight bearing for six weeks.

R1's incident report dated 2/26/25 at 1:54 a.m., identified R1 was found sitting on the floor by the doorway in her room. R1 stated she slid out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 bed after attempting to adjust herself in bed. Immediate action taken was vital signs, range of motion, neurological exam, and skin observation. Assisted back to bed with total mechanical lift. Intervention: colorful signs put in room to friendly remind/encourage resident to please use call light when needs assistance-we are here to help you. Although the analysis identified root cause of sliding out of bed there was no indication R1's care plan was revised to address the causal factors. R1's care plan previously amended on 2/1/25 for colorful signs put in room to friendly/encourage resident to please use call light and wait for staff assistance/help with all transfers. R1's incident report dated 3/4/25 at 2:32 a.m., identified R1 was found on the floor with back scratcher in hands. Resident stated, "I slid out of bed, same as always, went on the floor on my buttocks." Immediate action taken was vital signs, neurological check, skin observation, range of motion. Assisted back to bed via total mechanical lift. Facility investigation form dated 3/4/25, identified cause of fall stated she fell asleep while sitting on the edge of bed. New intervention added to care plan of one-hour checks while in bed. Although the incident report identified causal factor of sliding out of bed per R1 there was no indication R1's care plan was revised to include an intervention for sliding out of bed. During an interview on 2/28/25 at 4:23 p.m., nursing assistant (NA)-B stated prior to the fall on 2/4/25, shortly before 10:30 p.m., NA-B went into R1's room to find her sleeping in her wheelchair. NA-B pushed R1 next to her bed to complete a stand pivot transfer. However, during the transfer to the edge of the bed R1 seemed really weak and had difficulty standing. R1 stated she had to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 go to the bathroom so NA-B left the room to get the sit-to-stand mechanical lift because R1 was having too much difficulty with standing. NA-B explained staff could use mechanical lifts when residents suddenly became unable to complete transfers. This was also care planned for R1. When NA-B returned to the room R1 was seated on the floor next to her bed. NA-B stated trained medication aide (TMA)-A and himself assisted R1 from the floor using a full body mechanical lift and placed R1 in her wheelchair. LPN-C was not in the room during the transfer. NA-B indicated once R1 was in her wheelchair she requested to use the bathroom. TMA-A and NA-B used a sit-to-stand mechanical lift to transfer R1 from the wheelchair to the toilet. They raised R1 up in the lift, pushed her towards the bathroom, and as they were turning toward the toilet, R1 became weak in the legs and began hanging in the lift after letting go with her left hand and was hanging on to the lift bar with her right hand. R1 then reported she had pain then she heard a "pop" at which point she let go with her right arm. NA-B stated we then lowered R1 to the ground. NA-B informed LPN-C of the R1's fall and she came into R1's bathroom. R1 was then sent to the hospital. During a follow up interview on 3/5/25 at 11:19 a.m., NA-B stated he did not inform the LPN-C that R1 was weak and unable to stand prior to the fall from side of the bed at 10:30 p.m. NA-B stated, "I should have told the nurse she was weak before she fell at 10:30 p.m., but did not do this." During an interview on 3/4/25 at 2:37 p.m., LPN-C stated she was informed by NA-B of R1's fall on 2/4/25 at 10:30 p.m., When LPN-C entered R1's room R1 was seated on the floor next to her bed. LPN-C instructed staff to use the total mechanical lift to transfer her from the floor to her	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9	2 830		

Continued From page 9

wheelchair.

During an interview on 3/4/25 at 11:45 a.m., interim director of nursing (IDON) stated R1's falls were not investigated thoroughly to determine if R1's basic needs were met such as toileting and indicated the cause of R1's falls on 1/27/25, 2/1/25 and 2/4/25 was that she was attempting to go to the bathroom each time and that a toileting plan should have been added at that time due to R1 being dependent on staff with toileting.

During an interview on 3/6/25 at 10:29 a.m., R1 stated since her fall on 2/4/25, where she fractured her right clavicle, and has gone "backwards". R1 stated she was supposed to return to the assisted living now she was not able to return until she was able to do things for herself and was using the total mechanical lift now for all transfers.

R5's face sheet dated 3/5/25, identified diagnoses of fracture of left lower leg (broken bone in leg), Alzheimer's disease (progressive disease the destroys memory), history of falling, and bipolar disorder (disorder with episodes of mood swings).

R5's admission MDS dated 2/3/25, identified R5 had severe cognitive impairment and dependent for transfers and had 1 fall since admission without injury.

R5's ADL focus care plan dated 1/28/25, identified self-care deficit related to Alzheimer's disease and recent falls at home. Goal to improve current level of functioning. Interventions dated 1/28/25 identified for toilet use assist of two with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10	2 830		

total mechanical lift. Revised on 2/28/25 to use assist of one and gait belt. Transfer assist of one and gait belt stand pivot (please use total mechanical lift as needed to transfer into bed or wheelchair) not putting weight on left lower extremity.

R5's fall focus care plan dated 1/28/25, identified R5 is at risk for falls due to history of falls, weakness, and unsteady gait/balance. Goal will be free from falls. No interventions identified.

R5's focus care plan dated 1/29/25, identified R5 had impaired cognition. Goal will be able to communicate basic needs on daily basis. Interventions were to check on frequently due to self-transfer attempts for safety and to help potentially reduce falls.

Fall Risk Assessments completed on 2/8/25, 2/11/25, and 2/15/25, identified R5 was at high-risk for falls. Falls tool action plan not marked as initiated. No fall risk assessment was provided on admission.

Review of Facility's incident report log on 2/27/25, identified R5 had five falls between 1/29/25 to 2/22/25. R1 had two additional falls on 3/1/25 and 3/4/25.

The falls are identified as follows:
R5's incident report dated 1/29/25, identified a fall at 4:20 a.m., R5 was found seated on the floor with her back resting on the side of the bed. Bed was in lowest position and call light within reach. Immediate action taken was a fall mat placed on side of bed. Care plan intervention initiated on 1/29/25 with fall mat placed next to bed and frequent check due to self-transfer attempts for safety to help potentially reduce falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ____ B. WING ____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11	2 830		

R5's incident report dated 2/11/25, identified a fall at 7:45 p.m., R5 was in doorway of room. Immediate action taken was to remind resident on importance of using the call light when needing assistance and to not self-transfer. R5's fall record did not include a comprehensive analysis of fall nor identify possible root cause. R5's care plan revised on 2/11/25 to remind frequently to not self-transfer.

R5's incident report dated 2/15/25/25, identified a fall at 4:02 p.m., R5 was found on the floor in her room seated on her knees. Immediate action taken was assisted off the floor, vital signs, taken to the bathroom, and then placed in wheelchair. Facility fall investigation form dated 2/15/25, identified cause of incident was resident yelling for help, she was leaving her room to find help, and the care plan was amended to remind resident to put on the call light and a sign was put on her table.

R5's incident report dated 2/18/25 at 8:50 p.m., identified a fall when R5 was found scooting out of her room on her bottom. Immediate action taken was a skin assessment, vital signs, and range of motion. R5 was assisted by two staff using the total mechanical lift to bed. Facility investigation form dated 2/19/25, did not include a comprehensive fall analysis however identified causal factor of fall as resident was scooting on buttocks out of her room and she stated she was going to the movies. The care plan amended: if awake in room, encourage to come to commons area for better supervision. R5's care plan intervention revision on 2/19/25 if awake in bed, encourage to get up in wheelchair and come out of room into commons area for better supervision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ________ B. WING ________	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 12	2 830		

R5's incident report dated 2/22/25 at 12:00 a.m., identified R5 was found scooting on buttocks on the floor near her doorway. R5's fall record did not include a comprehensive analysis of the fall nor identify root cause and it was not evident R5's care plan was revised.

R5's incident report dated 3/1/25 at 9:45 p.m., identified R5 was found on floor scooting self on floor in the direction of the bathroom. Immediate action taken was vital signs, neurological exam, range of motion, and skin observation. R1 was incontinent of urine. Assisted by two staff with total mechanical lift to bed. Intervention added colorful signs placed in room reminding resident to use call light for help. R5's care plan revised on 3/2/25, to place colorful signs placed in room to remind resident to call for help. R5's fall record did not include a comprehensive analysis of the fall that included and addressed R5's toileting needs.

R5's incident report dated 3/3/25 at 9:15 pm., identified R5 was found lying on the floor. Immediate action taken was vital signs, neurological exam, body exam, range of motion. Assisted with two staff back to bed with total mechanical lift. Intervention of soft touch call light put in place. R5's care plan updated on 3/4/25 to soft touch call light put in place. R5's fall record did not include a comprehensive fall analysis nor identify potential root cause.

During an interview on 3/6/25 at 1:03 p.m., IDON stated R5's care plan interventions to remind to use the call light/signs would not be appropriate with her cognition. IDON further stated the falls for R1 and R5, a thorough investigation was not performed to determine if basic needs were met

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 13	2 830		

and to determine a root cause. "We tried to put interventions in place, but they are not always related to the root cause and should have been." DON also stated when the interdisciplinary team meets each week to discuss falls, we should be adding a summary in the resident's chart, but this has not happened lately. The care plan should be updated timely with any changes of new interventions/changes so staff are aware.

Review of the facility's Fall Prevention and Management policy dated 7/29/24, identified procedure for a fallen resident:
-Do not move resident.
-A nurse must observe the resident and perform a full-body exam to determine if there may be suspected injury and direct whether to move the resident.
-Obtain blood pressure, pulse, respiratory rate, pulse oximetry and temperature. Check blood sugar if resident is symptomatic of blood glucose issues.
-If the fall was not witnessed, neurological checks are required and must be documented in the medical record.
-Continue to monitor the resident's condition; communicate updates as needed.
-Review resident's medications for recent changes or medication that could contribute to a fall.
-If teaching is done, it must be documented in the medical record.
-Review and update care plan with any changes/new interventions.

Review of facility's Care Plan Policy dated 12/2/24, identified the care plan will be modified to reflect the care currently required/provided for the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ____ B. WING ____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 14 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure appropriate supervision and analaysis of falls occurs for fall prevention. The director of nursing or designee, should conduct measurable audits of fall to ensure analysis of the root cause if completed and identify if appropriate interventions are in place to prevent falls. The DON or designee should educate staff to those intervention. The results of audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		
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	21390		4/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 15 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP-where gown and gloves used for high contact resident care activities) was used for 1 of 3 residents(R3) observed for EBP. In addition, the facility failed to ensure handwashing/hand hygiene was implemented for 2 of 7 residents (R6, R7) observed for handwashing/hand hygiene. Findings include R3's face sheet dated 3/6/25, identified heart failure (condition in which heart does not pump blood as well as it should), and calculus of bile duct (bile duct stones). R3's care plan focus dated 4/16/24, identified enhanced barrier precautions indicated due to indwelling medical device (biliary drainage tube). Interventions to use gown and gloves when performing high contact activities (dressing, transferring, providing hygiene, repositioning, device care or wound care). During an observation on 2/27/25, at 11:15 am, R3 was in her room where nursing assistants	21390	Acknowledged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 16 (NA)-A and NA-C placed socks and pants on R3 with dressing, then applied a lift sling under her while turning her side to side. NA-A and NA-C then performed a transfer. NA-A and NA-C did not wear gown or gloves during cares or during the transfer. During an interview on 2/28/25 at 9:21 a.m., NA-A stated gown and gloves should be worn when performing any close contact care for any resident that is on EBP. R7's face sheet dated 3/5/25, identified diabetes mellitus (condition that affects how the body uses sugar as fuel), heart failure, and absence of left leg below knee. During an observation on 3/4/25 at 9:12 a.m., R7 was in bathroom seated on the toilet, NA-D applied gloves, however, did not perform hand hygiene before applying. NA-D then instructed R7 to stand and cleansed her perineal area (region located between the anus and genitals), NA-D then adjusted R7's clothing and adjusted R7's oxygen tubing on her face. NA-D did not remove gloves or perform hand hygiene after perineal cares. R6's face sheet dated 3/6/25, identified diabetes mellitus and kidney disease (condition where kidneys have been damaged). During an observation and interview on 3/4/25 at 9:30 a.m., R6 was seated on the toilet in the bathroom, NA-D entered R6's room and applied gloves. NA-D did not perform hand hygiene prior to applying gloves. NA-D washed R6's back and cleansed her perineal area. NA-D removed gloves and applied a new pair of gloves. Hand hygiene/handwashing was not performed prior to	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ____ B. WING ____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 17	21390		

applying new gloves. NA-D assisted R6 with a transfer to her wheelchair, then opened up R6's drawer and removed a shirt and placed it on R6's upper body. NA-D then took R6's drinking cup and left room to fill in the facility kitchenette, however, did not remove gloves or perform hand hygiene. NA-D stated hand hygiene should be done before and after entering a resident's room, before and after cares, before touching drinkware, and before and after removal of gloves.

During an interview on 3/4/25 at 12:33 p.m., director of nursing (DON) stated her expectation for staff to use EBP (gown and gloves) for any personal cares for a resident identified on these precautions and to perform handwashing/hand hygiene before and after leaving a room, before and after cares, after removal of gloves.

Review of the facility's Standard and Transmission Based Precautions dated 4/2/24, identified that enhanced barrier precautions (gown and gloves) needed during high-contact resident care activities for residents with chronic wounds, indwelling medical devices (central lines, urinary catheter, feeding tubes and tracheostomies).

Review of the facility's Hand Hygiene policy dated 3/29/22, identified all employees in patient care areas will adhere to the 4 Moments of Hand Hygiene.
1. Entering room.
2. Before clean task
3. After bodily fluid/glove removal
4. Exiting room

SUGGESTED METHO OF CORRECTION: The Director of Nursing (DON), ICP, or designee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: ______ B. WING ______	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 18 could review facility policies/procedures regarding isolation precautions for the resident and provide staff education regarding the policies and educate staff on appropriate PPE wear and handwashing/hand hygiene. They could also do environmental rounds, audits, and re-educatioon anytime isolation precautions are placed. The ICP should have formal training to be completed according to regulation and head the above measures. In additon, the DON or designee should review and ensure compliance with PPE and hand hygiene with audits to ensure policies are being followed to ensure on-going competence. The ICP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: 21 (twenty-one) DAYS	21390		