



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 19, 2024

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

RE: CCN: 245441
Cycle Start Date: July 10, 2024

Dear Administrator:

On August 15, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

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



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August 19, 2024

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

Re: Reinspection Results
Event ID: CD2512

Dear Administrator:

On August 15, 2024 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 July 10, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
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July 24, 2024

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

RE: CCN: 245441
Cycle Start Date: July 10, 2024

Dear Administrator:

On July 10, 2024, 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
Licensing and Certification Program
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 October 10, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 10, 2025 (six months after

Good Samaritan Society - Albert Lea

July 24, 2024

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



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



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July 24, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: CD2511

Dear Administrator:

The above facility was surveyed on July 10, 2024 through July 10, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

Good Samaritan Society - Albert Lea

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

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

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
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.



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

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

PRINTED: 08/09/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245441	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/10/2024
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ALBERT LEA	STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>On 7/10/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed H54415540C (MN00104752), with deficiencies cited at F842 and F684.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000		
F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility</p>	F 684	Preparation and execution of this	8/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 07/31/2024
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	<p>Continued From page 1</p> <p>failed to ensure routine weekly skin assessments for impaired skin integrity for 2 of 3 residents (R1, R2) who had impaired skin integrity.</p> <p>Findings include:</p> <p>R1's Minimum Data Set (MDS) quarterly review dated 6/12/24, identified R1 had severe cognitive impairment. Diagnoses included cancer, and an open lesion with application of non-surgical dressings.</p> <p>R1's care plan revised on 3/21/23, indicated R1 had a potential impairment to skin integrity with a non-healing lesion on the top of his head. Interventions included to monitor location, size and treatment of skin injury, report abnormalities including failure to heal, signs/symptoms of infection, maceration, etc. to health care provider. Avoid scratching and keep hands and body parts from excessive moisture.</p> <p>R1's Wound Data Collection identified on 5/4/24, an initial data collection for the growth on top of R1's head. The assessment did not include wound measurements and a description of the wound.</p> <p>Review of R1's record did not include weekly comprehensive wound assessments for the growth on R1's head; the record included the following measurements recorded as length by (x) width x depth: 5/18/24- 4.5 centimeters (CM) x 5.5 cm x 2.5 cm 5/23/24- 5.5 cm x 6.0 cm x 2.5 cm 5/30/24- 5.0 cm x 1.5 cm x 5.0 cm 6/5/24- 5.5 cm x 5.5 cm no depth measured 6/19/24- 7.5 cm x 6.0 cm x 2.5 cm 6/30/24- 6.0 cm x 8.0 cm x 2.5 cm</p>	F 684	<p>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.</p> <p>F684 Quality of Care R1 and R2 had impaired skin integrity. There was a lack of documentation on measurements and wound assessments in the electronic medical record during the investigation on July 10, 2024. 1. Resident R1 and R2 were noted to have skin impairment based on review of their electronic medical record during the survey of the care center on July 10, 2024. Resident R1 no longer resides at the care center. Resident R2 had a review of wound documentation to ensure thorough completion in a timely manner. The UDAs for resident R2 were reviewed and the schedules were reset to ensure completion in a timely manner to avoid any missing observations or assessments in the future. These items were completed on July 24, 2024, by the DNS. DNS reviewed items again on August 5, 2024, to ensure completion.</p>	

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F 684	<p>Continued From page 2</p> <p>Missed weekly measurements included 5/11/24, 6/1/24, 6/12/24, 6/30/24, and 7/7/24.</p> <p>R2's face sheet dated 7/10/24, identified diagnoses included hemiplegia and hemiparesis, gout, anxiety disorder, and bilateral primary osteoarthritis.</p> <p>R2's care plan revision dated 7/9/24, identified suspected deep tissue injury (SDTI) to the right great toe on 6/8/24, stage 3 pressure ulcer on back of left lower leg on 7/8/24. Interventions included to reposition in bed and chair every two hours and as needed, make sure heels are floated at all times with pillows, keep covers off of feet with use of foot cradle at end of bed. Assess/record/monitor wound healing daily with wound data collection user defined assessment (UDA), and weekly wound UDA. Report improvements and declines to the health care provider.</p> <p>R2's UDA wound data collection dated 6/8/24, identified an initial wound data collection for the SDTI of right great toe. No measurements or wound description provided with assessment. The Wound Data Collection had been completed daily from 6/8/24-7/10/24 but did not include consistent descriptions of the wound or measurements.</p> <p>R2's SDTI right great toe wound was measured: -6/20/24- 1.9 cm x 1.3 cm -6/28/24- 1.4 cm x 0.8 cm</p> <p>R2's did not include wound assessments for 6/15/24 and 7/5/24.</p>	F 684	<p>2. All residents have the potential to be affected by the deficient practice. Specifically, residents with skin impairment. An extensive review of all residents was completed and all residents who have skin impairment have been noted. A review of documentation was completed, and updates were made as needed. During the review it was noted that there were missed measurements and wound assessments with resident R2. All residents were reviewed to ensure that documentation schedules were made and accurate to ensure that measurements and documentation are done in the appropriate timeframe. This was completed by the DNS on July 24, 2024.</p> <p>3. To ensure systemic changes are sustained all nurses will receive education via meetings and handouts covering the information on GSS policies and procedures, including The Pressure Ulcer/Wound Care Resource Packet and The Nursing Documentation Guidelines, Timeliness- rehab/skilled. This will ensure that all nurses in the care center are able to complete the necessary documentation needed for residents with skin impairment and that it is completed in a timely manner, including the appropriate timeframe of measuring wounds at least once every seven days. The education provided will also ensure that nurses are aware that they must fully assess all new wounds and have supporting documentation that the wound was assessed in the electronic medical record.</p>	

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F 684	<p>Continued From page 3</p> <p>During an interview on 7/10/24 at 10:59 a.m., registered nurse (RN)-B stated all wounds including pressure, skin tears, and surgical incisions were supposed to be assessed every every Wednesday and Sunday.</p> <p>During an interview on 7/10/24 at 11:37 a.m., clinical manager (CM)-A indicated she was the person responsible for wound tracking. CM-A explained wound measurements had not been followed up on in awhile because she had been gone for most of June. CM-A reviewed wound measurements and acknowledged missing measurements for R1.</p> <p>During an interview on 7/10/24 at 2:57 p.m., Administrator, assistant director of nursing (ADON), and infection preventionist (IP) were present. IP stated wounds should be measured at least weekly.</p> <p>The Pressure Ulcer/Wound Care Resource Packet-rehab/skilled revised 6/5/24, identified wound care management may include the management and treatment of surgical wounds, pressure ulcers, diabetic ulcers and skin conditions, as well as arterial and venous ulcers.</p>	F 684	<p>This will ensure that any new wound is noted and assessed so a plan of care can be made to help aid in the healing of the wound and attempt to avoid any complications from the wound. A nurse staff meeting is scheduled for August 5, 2024 to provide education to the nurses. Wounds and measurements will be reviewed in the care center's weekly interdisciplinary team meetings. The clinical manager received one-on-one education with the DNS on delegation of responsibilities to ensure that the deficient practice would not happen in the future on July 24, 2024. The floor nurse who was working when the deficient practice occurred received one-on-one education on August 6, 2024, with the DNS. These steps will ensure that the deficient practice does not occur again.</p> <p>4. The DNS or designee will perform electronic medical records audits on random residents with wounds to ensure completion of documentation twice a week for four weeks and then weekly for eight weeks. The audit will include UDA completion and completion of wound measurements. Audit results will be reviewed by the QAPI committee and appropriate follow-up initiated to ensure compliance is sustained.</p> <p>5. The DNS will assure correction of this deficiency by August 9, 2024</p>		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		8/9/24	

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F 842	<p>Continued From page 4</p> <p>§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <ul style="list-style-type: none"> (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <ul style="list-style-type: none"> (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. 	F 842		

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F 842	<p>Continued From page 5</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <ul style="list-style-type: none"> (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. <p>§483.70(i)(5) The medical record must contain-</p> <ul style="list-style-type: none"> (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews, and document review the facility failed to maintain accurate medical records for 1 of 3 residents (R1) reviewed related to wound management.</p> <p>Findings include:</p> <p>R1's Minimum Data Set (MDS) quarterly review dated 6/12/24, identified R1 had severe cognitive impairment. Diagnoses included cancer, and an open lesion with application of non-surgical dressings.</p>	F 842	<p>F842- Resident Records-Identifiable Information</p> <p>1. Resident R1 no longer resides at the care center. Staff that were involved with the care of resident R1 on the day that the deficiency in practice occurred received one-on-one education with the DNS to ensure that the deficiency in practice would not happen again. This education was provided on July 24, 2024 with the clinical manager for the unit that the resident was residing in as she was made</p>	

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F 842	<p>Continued From page 6</p> <p>R1's care plan revised on 3/21/23, identified a potential impairment to skin integrity with a non-healing lesion on the top of his head. Interventions included to monitor location, size and treatment of skin injury, report abnormalities including failure to heal, signs/symptoms of infection, maceration, etc. to health care provider.</p> <p>Review of R1's progress notes included a change in skin condition that was identified on 7/8/24 however was not documented until 7/10/24.</p> <p>R1's progress note with a created date of 7/10/24 at 10:04 a.m. and documented effective date of 7/8/24, identified R1's family member had been notified of maggots in the wound on top of R1's head and what staff were doing for it. The note did not include the time R1's family was notified.</p> <p>R1's progress note with a created date of 7/10/24 at 11:09 a.m., and documented effective date of 7/8/24, identified R1 had maggots in the lesion on his head. Nurse practitioner was aware and had staff irrigate the lesion. Nurse practitioner saw the maggots.</p> <p>No further information pertaining to the extent of maggot infestation of wound and subsequent monitoring was evident.</p> <p>During an interview on 7/10/24 at 11:17 a.m., nursing assistant (NA)-A stated R1 would take the dressing off at night. NA-A noted R1's dressing was on when she got him up on 7/8/24 around 9:45 a.m. and the nurse changed the dressing and found the maggots.</p> <p>During an interview on 7/10/24 at 10:04 a.m.,</p>	F 842	<p>aware of the change in condition, but failed to ensure proper documentation was entered into the electronic medical record. The floor nurse who worked on the day of the deficiency received one-on-one education on August 6, 2024, to ensure that the deficient practice would not happen again. Education reviewed with both staff members included: how to document a change in condition, timeliness of documentation, and what documentation needs to be completed for the change of education to be noted and information sent to the provider and the resident or representative. Documentation was entered into the electronic medical record to ensure that it was present.</p> <p>2. All residents have the potential to be affected by the deficient practice. Specifically, residents with wounds. A comprehensive review of the electronic medical records of residents was conducted of all residents with wounds to ensure that proper documentation and notes were in place. Residents with a change in condition were reviewed to ensure that documentation had been entered into the electronic medical record on any change in condition to ensure that it was completed in a timely manner and complete. This was completed by the DNS on July 24, 2024.</p> <p>3. To ensure that systemic changes are sustained, all nurses were educated on timely documentation utilizing the policy Nursing Documentation Guidelines, Timeliness in a nurse meeting that will</p>	

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

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FORM APPROVED
OMB NO. 0938-0391

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F 842	<p>Continued From page 7</p> <p>Registered nurse (RN)-A stated she thought sometime during the night on 7/8/24 R1 had pulled off the scab that had been on the top of his head. RN-A had clinical manager (CM)-A examine the wound and CM-A found maggots in the wound. RN-A stated on 7/8/24 the maggots were very tiny, she rinsed the top of R1's head with vinegar in the shower and applied xeroform and an ABD (absorbent dressing). On 7/9/24, the maggots had become large enough to pick off with a tweezers and on 7/10/24 the maggots were gone.</p> <p>During an interview on 7/10/24 at 11:37 a.m., CM-A stated on 7/8/24 while observing the dressing change she saw little things moving in the wound. CM-A stated R1 had always pulled the dressings off and staff were not able to keep any dressings on very well. CM-A stated the nurse practitioner (NP) had them try xeroform with an ABD pad over the wound without an order for the first day to see if R1 would keep it on. The NP came back the next day and gave an order for the dressing. CM-A stated on 7/9/24, there were a few maggots and they moved very fast so they used a tweezers to get them before the maggots could get into the wound crevices. CM-A stated she had not documented any of the treatments or findings. CM-A reviewed R1's record and indicated no documentation had been completed on the wound or the presence of maggots. CM-A added late entry notes in to the chart about notifying family and the nurse practitioner.</p> <p>During an interview on 7/10/24 at 2:57 p.m., Administrator, assistant director of nursing (ADON), and infection preventionist (IP) the ADON stated it was very important to have timely documentation. ADON stated there were times</p>	F 842	<p>occur on August 5, 2024. This education includes handouts of the policy, a slide show presentation, and an open question and answer session to ensure that staff have the knowledge and understanding of documenting any change in condition in a timely manner. This will ensure that staff are able to observe a change in condition, document the change, and be able to notify the provider and resident or resident contact to ensure that the resident is able to be cared for with the highest quality of care possible, and decrease the risks of complication related to a change in condition. This education includes what UDAs and progress notes need to be made and what they need to contain to be complete notes. The clinical manager received one-one education with the DNS on the previously stated policy on July 25, 2024, and she also attended the meeting that was scheduled on August 5, 2024. The floor nurse who worked when the deficiency occurred received one-on-one education on August 6, 2024, with the DNS. This will ensure that the deficient practice will not happen again.</p> <p>4. The DNS or designee will complete audits on random residents noted to have changes in condition to ensure that there is timely documentation of the changes in the electronic medical records twice a week for four weeks and then weekly for eight weeks. Audit results will be reviewed by the QAPI committee and appropriate follow-up initiated to ensure compliance is sustained.</p>	

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F 842	Continued From page 8 when documentation was not completed timely and a late entry should be added in the medical record so staff could know what was happening with a resident. The Nursing Documentation Guidelines, Timeliness-rehab/skilled revised on 5/6/24, identified the purpose to systematically and continuously collect information about the health status of the resident and to ensure appropriate documentation is completed in a timely manner. Incidental charting-day-to-day type documentation of specific occurrences will be completed by a licensed nurse in the appropriate progress note determined by the content of the note.	F 842	5. The DNS will ensure correction of this deficiency by August 9, 2024.	

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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: On 7/10/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 07/31/24
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2 000	<p>Continued From page 1</p> <p>identify the date when they will be completed.</p> <p>The following complaints were reviewed: H54415540C (MN00104752) with a licensing order issued at 0675.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p>	2 000		

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2 000	Continued From page 2	2 000		
2 625	<p>MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General</p> <p>Subpart 1. In general. Each resident's clinical record, including nursing notes, must include:</p> <ul style="list-style-type: none"> A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; 	2 625		8/9/24

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2 625	<p>Continued From page 3</p> <p>J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400.</p> <p>This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review the facility failed to maintain accurate medical records for 1 of 3 residents (R1) reviewed related to wound management.</p> <p>Findings include:</p> <p>R1's Minimum Data Set (MDS) quarterly review dated 6/12/24, identified R1 had severe cognitive impairment. Diagnoses included cancer, and an open lesion with application of non-surgical dressings.</p> <p>R1's care plan revised on 3/21/23, identified a potential impairment to skin integrity with a non-healing lesion on the top of his head. Interventions included to monitor location, size and treatment of skin injury, report abnormalities including failure to heal, signs/symptoms of infection, maceration, etc. to health care provider.</p>	2 625	Corrected	

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2 625	<p>Continued From page 4</p> <p>Review of R1's progress notes included a change in skin condition that was identified on 7/8/24 however was not documented until 7/10/24.</p> <p>R1's progress note with a created date of 7/10/24 at 10:04 a.m. and documented effective date of 7/8/24, identified R1's family member had been notified of maggots in the wound on top of R1's head and what staff were doing for it. The note did not include the time R1's family was notified.</p> <p>R1's progress note with a created date of 7/10/24 at 11:09 a.m., and documented effective date of 7/8/24, identified R1 had maggots in the lesion on his head. Nurse practitioner was aware and had staff irrigate the lesion. Nurse practitioner saw the maggots.</p> <p>No further information pertaining to the extent of maggot infestation of wound and subsequent monitoring was evident.</p> <p>During an interview on 7/10/24 at 11:17 a.m., nursing assistant (NA)-A stated R1 would take the dressing off at night. NA-A noted R1's dressing was on when she got him up on 7/8/24 around 9:45 a.m. and the nurse changed the dressing and found the maggots.</p> <p>During an interview on 7/10/24 at 10:04 a.m., Registered nurse (RN)-A stated she thought sometime during the night on 7/8/24 R1 had pulled off the scab that had been on the top of his head. RN-A had clinical manager (CM)-A examine the wound and CM-A found maggots in the wound. RN-A stated on 7/8/24 the maggots were very tiny, she rinsed the top of R1's head with vinegar in the shower and applied xeroform and an ABD (absorbent dressing). On 7/9/24, the</p>	2 625		
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2 625	<p>Continued From page 5</p> <p>maggots had become large enough to pick off with a tweezers and on 7/10/24 the maggots were gone.</p> <p>During an interview on 7/10/24 at 11:37 a.m., CM-A stated on 7/8/24 while observing the dressing change she saw little things moving in the wound. CM-A stated R1 had always pulled the dressings off and staff were not able to keep any dressings on very well. CM-A stated the nurse practitioner (NP) had them try xeroform with an ABD pad over the wound without an order for the first day to see if R1 would keep it on. The NP came back the next day and gave an order for the dressing. CM-A stated on 7/9/24, there were a few maggots and they moved very fast so they used a tweezers to get them before the maggots could get into the wound crevices. CM-A stated she had not documented any of the treatments or findings. CM-A reviewed R1's record and indicated no documentation had been completed on the wound or the presence of maggots. CM-A added late entry notes in to the chart about notifying family and the nurse practitioner.</p> <p>During an interview on 7/10/24 at 2:57 p.m., Administrator, assistant director of nursing (ADON), and infection preventionist (IP) the ADON stated it was very important to have timely documentation. ADON stated there were times when documentation was not completed timely and a late entry should be added in the medical record so staff could know what was happening with a resident.</p> <p>The Nursing Documentation Guidelines, Timeliness-rehab/skilled revised on 5/6/24, identified the purpose to systematically and continuously collect information about the health status of the resident and to ensure appropriate</p>	2 625		
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2 625	<p>Continued From page 6</p> <p>documentation is completed in a timely manner. Incidental charting-day-to-day type documentation of specific occurrences will be completed by a licensed nurse in the appropriate progress note determined by the content of the note</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 625		
2 830	<p>MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General</p> <p>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.</p> <p>This MN Requirement is not met as evidenced</p>	2 830		8/9/24

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2 830	<p>Continued From page 7</p> <p>by: Based on interview and record review the facility failed to ensure routine weekly skin assessments for impaired skin integrity for 2 of 3 residents (R1, R2) who had impaired skin integrity.</p> <p>Findings include:</p> <p>R1's Minimum Data Set (MDS) quarterly review dated 6/12/24, identified R1 had severe cognitive impairment. Diagnoses included cancer, and an open lesion with application of non-surgical dressings.</p> <p>R1's care plan revised on 3/21/23, indicated R1 had a potential impairment to skin integrity with a non-healing lesion on the top of his head. Interventions included to monitor location, size and treatment of skin injury, report abnormalities including failure to heal, signs/symptoms of infection, maceration, etc. to health care provider. Avoid scratching and keep hands and body parts from excessive moisture.</p> <p>R1's Wound Data Collection identified on 5/4/24, an initial data collection for the growth on top of R1's head. The assessment did not include wound measurements and a description of the wound.</p> <p>Review of R1's record did not include weekly comprehensive wound assessments for the growth on R1's head; the record included the following measurements recorded as length by (x) width x depth: 5/18/24- 4.5 centimeters (CM) x 5.5 cm x 2.5 cm 5/23/24- 5.5 cm x 6.0 cm x 2.5 cm 5/30/24- 5.0 cm x 1.5 cm x 5.0 cm 6/5/24- 5.5 cm x 5.5 cm no depth measured 6/19/24- 7.5 cm x 6.0 cm x 2.5 cm</p>	2 830	Corrected	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00131	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2024
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ALBERT LEA	STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007
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2 830	<p>Continued From page 8</p> <p>6/30/24- 6.0 cm x 8.0 cm x 2.5 cm</p> <p>Missed weekly measurements included 5/11/24, 6/1/24, 6/12/24, 6/30/24, and 7/7/24.</p> <p>R2's face sheet dated 7/10/24, identified diagnoses included hemiplegia and hemiparesis, gout, anxiety disorder, and bilateral primary osteoarthritis.</p> <p>R2's care plan revision dated 7/9/24, identified suspected deep tissue injury (SDTI) to the right great toe on 6/8/24, stage 3 pressure ulcer on back of left lower leg on 7/8/24. Interventions included to reposition in bed and chair every two hours and as needed, make sure heels are floated at all times with pillows, keep covers off of feet with use of foot cradle at end of bed. Assess/record/monitor wound healing daily with wound data collection user defined assessment (UDA), and weekly wound UDA. Report improvements and declines to the health care provider.</p> <p>R2's UDA wound data collection dated 6/8/24, identified an initial wound data collection for the SDTI of right great toe. No measurements or wound description provided with assessment. The Wound Data Collection had been completed daily from 6/8/24-7/10/24 but did not include consistent descriptions of the wound or measurements.</p> <p>R2's SDTI right great toe wound was measured: -6/20/24- 1.9 cm x 1.3 cm -6/28/24- 1.4 cm x 0.8 cm</p> <p>R2's did not include wound assessments for 6/15/24 and 7/5/24.</p>	2 830		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ALBERT LEA	STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007
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2 830	<p>Continued From page 9</p> <p>During an interview on 7/10/24 at 10:59 a.m., registered nurse (RN)-B stated all wounds including pressure, skin tears, and surgical incisions were supposed to be assessed every every Wednesday and Sunday.</p> <p>During an interview on 7/10/24 at 11:37 a.m., clinical manager (CM)-A indicated she was the person responsible for wound tracking. CM-A explained wound measurements had not been followed up on in awhile because she had been gone for most of June. CM-A reviewed wound measurements and acknowledged missing measurements for R1.</p> <p>During an interview on 7/10/24 at 2:57 p.m., Administrator, assistant director of nursing (ADON), and infection preventionist (IP) were present. IP stated wounds should be measured at least weekly.</p> <p>The Pressure Ulcer/Wound Care Resource Packet-rehab/skilled revised 6/5/24, identified wound care management may include the management and treatment of surgical wounds, pressure ulcers, diabetic ulcers and skin conditions, as well as arterial and venous ulcers.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents whom have impaired skin integrity to assure they are receiving the necessary treatment/services to prevent infection and deterioration of wounds and to promote healing. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services</p>	2 830		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00131	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2024
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2 830	<p>Continued From page 10</p> <p>are implemented. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 830		