*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
October 25, 2024

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

RE: CCN: 245441
Cycle Start Date: September 11, 2024

Dear Administrator:

On October 2, 2024, we notified you a remedy was imposed. On October 21, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 16, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 11, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 2, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 11, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 16, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed 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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Administrator
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75507 240th Street
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Re: Reinspection Results
Event ID:  JQ3W12

Dear Administrator:

On October 21, 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 September 11, 2024.  At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>On 9/10/24 and 9/11/24, 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.<br><br>The following complaint was reviewed H54417791C (MN00106296, MN00106356) with a deficiency cited at F689 and F880.<br>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.<br><br>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 | Past noncompliance: no plan of correction required. | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to provide safe transfers and follow the care plan to prevent accidents for 1 of 3 residents (R1) | F 689 | Past noncompliance: no plan of correction required. | |

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

Electronically Signed | 10/09/2024

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 689 | Continued From page 1<br>reviewed for falls. The facility's failure resulted in harm when R1 fell and sustained a left hip fracture that required surgical intervention. The facility implemented immediate corrective actions prior to survey and is issued at past non-compliance.<br><br>Findings include:<br><br>R1's quarterly Minimum Date Set (MDS) dated 7/12/24, indicated R1 did not have cognitive impairment. R1's diagnoses included legally blind and diabetes. R1 required one staff assist for staff transfers, toileting hygiene, upper and lower body dressing, and walking. R1 received anticoagulants (blood thinning medications).<br><br>R1's fall care plan dated 12/1/23, indicated R1 was at risk for falls due to vision deficit. R1's activities of daily living (ADLs) care plan with the intervention dated 6/10/22, indicated R1 required one staff assist with gait belt for ambulation to and from the bathroom, meals, and activities.<br><br>Review of video recording dated 8/24/24 at 6:58 a.m., revealed R1 entered his room from his bathroom with assist from nursing assistant (NA)-C and gait belt. NA-C was holding onto the back of the gait belt and R1's left lower forearm. NA-C moved around R1 and let go of gait belt and R1's wrist. NA-C then stepped away from R1 toward wheelchair. R1 lost his balance and fell backward landing on floor in front of doorway. R1 hit his head on bedside stand inside of door. Licensed practical nurse (LPN)-B opened the door and asked, "what happened?" NA-C replied "R1 slipped". R1 stated he thought his hip was broken and was in pain. LPN-B and NA-C moved R1 further away from the doorway. R1 continued | F 689 | | |

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| F 689 | Continued From page 2<br>to express pain in his hip and thought it was broken. R1 refused to be transferred from the floor and LPN-B directed other staff to call for ambulance.<br><br>R1's progress note dated 8/24/24 at 7:14 a.m., indicated R1 was transferred to the emergency department via ambulance due to fall.<br><br>R1's progress note dated 8/24/24 at 9:30 p.m., call was placed to emergency department for update. R1 was transferred to higher level of care hospital for displaced left hip fracture.<br><br>R1's progress note dated 9/3/24 at 1:55 p.m., R1 returned to the facility following hospital surgical repair of fractured left hip.<br><br>During an interview on 9/11/24 at 9:34 a.m., NA-C stated on 8/24/24, she was walking R1 to his wheelchair from bathroom with the gait belt on. NA-C let go of the gait belt to secure the wheelchair and R1 fell and broke his hip. NA-C stated she should not have let go of the gait belt. NA-C explained she was placed on leave and was re-educated on safe transfers and gait belt usage prior to returning to work.<br><br>During an interview on 9/11/24 at 7:03 a.m., LPN-B stated she was working the morning R1 fell on 8/24/24. LPN-B had been passing medications when she heard a bang and R1 yelling. When she entered the room, R1 was lying in front of the door. LPN-B was under the impression R1's care plan was followed at the time of the fall based on NA-C's report that R1 had slipped when he was being walked to the bathroom. LPN-B indicated NA-C should not have let go of the gait belt until R1 was safely seated. | F 689 | | |

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| F 689 | Continued From page 3<br><br>During an interview on 9/11/24 at 12:34 p.m., director of nursing (DON) stated when he first learned about the incident he was told R1 slipped and fell. DON thought the care plan was being followed until on 8/27/24, FM-A brought in a copy of the video. Administrator and DON watched the video with family present and were able to see NA-C had let go of the gait belt and R1 falling to the floor as a result of losing his balance. After viewing the video, the facility re-educated all staff on 8/27/24, on safe transfers and expectations for using the gait belt during transfers.<br><br>Review of the facility's attestation statement "Plan of Care/Gait Belt dated 8/2024 in conjunction with the facility staff nursing roster and "Gait Belt Transfer/Ambulation Audits" indicated all staff acknowledged they received and understood education on the use of gait belt and following the care plan of residents within the facility between 8/27/24 and 9/5/24. "Staff are to check the Kardex/care plan prior to assisting residents with mobility, including transfers and/or ambulation. The Kardex/care plan includes use of gait belt for transfers/ambulation, staff are to hold on to the gait belt the entire time until the resident is safely seated on the destination surface."<br><br>Review of facility policy titles Gait-Transfer Belt, dated 5/2/24, indicated gait belts were to be used with assisted ambulation unless medically contraindicated. A gait belt was never to be used as a lifting device, only for stabilization.<br>-4. When holding the belt, an underhand grasp should be used.<br>-6. Transfer or ambulate resident and remove belt. | F 689 | | |

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| F 880 | Continued From page 4 | F 880 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; | F 880 | | 10/16/24 |

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| F 880 | Continued From page 5<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions ((EBPs), an infection control intervention designed to reduce the spread of infections which employs targeted gown and glove use during high contact resident care activities) were implemented for 2 of 2 residents (R4, R6) observed with implanted medical devices. | F 880 | 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 | |

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| F 880 | Continued From page 6<br><br>Findings include:<br><br>R4<br>R4's quarterly Minimum Data Set (MDS) dated 7/3/24, indicated R4 was dependent on staff with all activities of daily living (ADLs). R4's diagnoses included multiple sclerosis, ostomy (surgical opening for his bowels), and urinary catheter.<br><br>R4's infection care plan dated 4/5/24, indicated R4 required EPBs related to supra pubic catheter (a tube that drains urine from the bladder through a small incision in the lower abdomen) and ostomy (a surgical opening for his bowels on abdomen). Interventions directed staff to don a gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking, and changing, device care and/or use, and wound care.<br><br>During an observation on 9/10/24 at 4:56 p.m., nursing assistant (NA)-E assisted NA-M to get R4 out of bed. NA-M had on personal protective equipment (PPE) including gloves, gown, and a mask. NA-E did not have a gown or gloves on when she assisted NA-M with turning R4 over, pulling R4's pants up and placing the mechanical lift sling underneath him. Then NA-E assisted with transferring R4 out of bed to his wheelchair using the full body mechanical lift.<br><br>During an interview on 9/10/24 at 5:05 p.m., NA-E stated she should have put on gown and gloves but did not think about it, even though NA-M had on gown, gloves, and mask. NA-E stated R4 was on EBP's and supplies were stored on his door. | F 880 | 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.<br><br>F880- Infection Prevention & Control<br>1) Resident R4 is on Enhanced Barrier Precautions (EBP) due to a supra pubic catheter and an ostomy. Resident R6 is on EBP Precautions due to a urinary catheter and a feeding tube. Both residents had a review of their care plan completed by the DON on September 12, 2024, to ensure that EBP are listed so staff are aware of the precautions. The DON ensured that supplies were available for staff to utilize for EBP on September 12, 2024, and supplies and signage were appropriately available for staff. Education was provided for staff on September 11, 2024, to ensure that EBP is being followed for the residents listed.<br>2) All residents have the potential to be affected by the deficient practice. Specifically, residents with the need to have Enhanced Barrier precautions. The DON did a review of care plans for all residents September 12 through September 18 to ensure that EBP was listed appropriately on all residents who need EBP. Supplies were checked to ensure that they were readily available for staff to use, and all supplies were well stocked on September 11, 2024 to ensure that EBP can be properly followed for all residents who are required to have these | |

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| F 880 | Continued From page 7<br><br>R6<br>R6's quarterly MDS dated 7/3/24, indicated R6 had an indwelling urinary catheter and a feeding tube (tubes mainly inserted into the gastrointestinal (GI) tract to provide a patient with a route for enteral nutrition). R6 required partial to substantial assistance from staff with his ADLs.<br><br>R6's infection care plan dated 4/5/24, indicated R6 required EBPs related to indwelling catheter. Interventions directed Staff to don a gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking, and changing, device care and/or use, and wound care. R6's care plan failed to identify a need for EBP's with G-tube (gastrostomy tube, a type of feeding tube) care and the administration of medications via G-tube.<br><br>During an observation on 9/11/24 at 10:10 a.m., licensed practical nurse (LPN)-D entered R6's room without putting a gown on and used hand sanitizer but did not put on gloves. LPN-D turned off R6's tube feeding pump and disconnected the tubing from R6's feeding port. LPN-D prepared R6's medications to administer via feeding tube then put gloves on prior to administering them.<br><br>During an interview on 9/11/24 at 2:09 p.m., LPN-D stated she did not know she needed to wear a gown while administering medications via G-tube. LPN-D indicated she was not aware EBP's were necessary when administering medications through a feeding tube.<br><br>During an interview with the director of nursing | F 880 | precautions in place.<br>3) To ensure systemic changes are sustained education was provided to all nursing staff who have close interactions with residents who need EBP on October 15, 2024 through an all staff meeting. The policy Standard and Transmission Based Precautions was used to educate the staff through a PowerPoint presentation with a questions and answer session to follow to ensure understanding of the education provided.<br>4) The corrective actions will be monitored to ensure that the deficient practice will not recur via auditing of Enhanced Barrier Precautions. The DNS or designee will audit the Enhanced Barrier Precaution care plan, utilization of EBP, and supplies twice a week for four weeks and then once a week for eight weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained.<br>5) The date of correction for this will be October 16, 2024 and will be ensured by the DNS. | |

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| F 880 | Continued From page 8<br>(DON) on 9/11/24 at 12:14 p.m., the DON stated it was his expectation that PPE be worn by all staff when indicated. DON reviewed the facility policy and confirmed the medications through the G-tube would require PPE to be worn as the contents of the g-tube or stomach could come back out of the G-tube and get on staff or resident.<br><br>Review of facility policy titled Standard and Transmission-Based Precautions, dated 4/2/24 indicated the following:<br>-Enhanced barrier precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high- contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.<br>-Enhanced barrier Precautions are needed for residents with chronic wounds (Pressure Ulcers, Diabetic Foot Ulcers, Unhealed surgical wounds, and venous statis ulcers) and Residents with Indwelling Medical devices (central lines, hemodialysis catheters, indwelling urinary catheters, feeding tubes, and tracheotomies).<br>-High-Contact Resident Care Activities include transfers, dressing, assisting during bathing, providing hygiene, changing briefs, or assisting with toileting, working with resident in therapy gym, specifically when anticipating close physician contact while assisting with transfers and mobility, changing linens, device care or use (central line, urinary catheter, feeding tube, tracheostomy), and wound care. | F 880 | | |

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| F 000 | INITIAL COMMENTS<br><br>On 9/10/24 and 9/11/24, 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.<br><br>The following complaint was reviewed H54417791C (MN00106296, MN00106356) with a deficiency cited at F689 and F880.<br>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.<br><br>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 | Past noncompliance: no plan of correction required. | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to provide safe transfers and follow the care plan to prevent accidents for 1 of 3 residents (R1) | F 689 | Past noncompliance: no plan of correction required. | |

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

Electronically Signed | 10/09/2024

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 |
|---|---|---|---|
| | 245441 | A. BUILDING _____ B. WING _____ | C 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOOD SAMARITAN SOCIETY - ALBERT LEA | 75507 240TH STREET ALBERT LEA, MN 56007 |

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| F 689 | Continued From page 1<br>reviewed for falls. The facility's failure resulted in harm when R1 fell and sustained a left hip fracture that required surgical intervention. The facility implemented immediate corrective actions prior to survey and is issued at past non-compliance.<br><br>Findings include:<br><br>R1's quarterly Minimum Date Set (MDS) dated 7/12/24, indicated R1 did not have cognitive impairment. R1's diagnoses included legally blind and diabetes. R1 required one staff assist for staff transfers, toileting hygiene, upper and lower body dressing, and walking. R1 received anticoagulants (blood thinning medications).<br><br>R1's fall care plan dated 12/1/23, indicated R1 was at risk for falls due to vision deficit. R1's activities of daily living (ADLs) care plan with the intervention dated 6/10/22, indicated R1 required one staff assist with gait belt for ambulation to and from the bathroom, meals, and activities.<br><br>Review of video recording dated 8/24/24 at 6:58 a.m., revealed R1 entered his room from his bathroom with assist from nursing assistant (NA)-C and gait belt. NA-C was holding onto the back of the gait belt and R1's left lower forearm. NA-C moved around R1 and let go of gait belt and R1's wrist. NA-C then stepped away from R1 toward wheelchair. R1 lost his balance and fell backward landing on floor in front of doorway. R1 hit his head on bedside stand inside of door. Licensed practical nurse (LPN)-B opened the door and asked, "what happened?" NA-C replied "R1 slipped". R1 stated he thought his hip was broken and was in pain. LPN-B and NA-C moved R1 further away from the doorway. R1 continued | F 689 | | |

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| F 689 | Continued From page 2<br>to express pain in his hip and thought it was broken. R1 refused to be transferred from the floor and LPN-B directed other staff to call for ambulance.<br><br>R1's progress note dated 8/24/24 at 7:14 a.m., indicated R1 was transferred to the emergency department via ambulance due to fall.<br><br>R1's progress note dated 8/24/24 at 9:30 p.m., call was placed to emergency department for update. R1 was transferred to higher level of care hospital for displaced left hip fracture.<br><br>R1's progress note dated 9/3/24 at 1:55 p.m., R1 returned to the facility following hospital surgical repair of fractured left hip.<br><br>During an interview on 9/11/24 at 9:34 a.m., NA-C stated on 8/24/24, she was walking R1 to his wheelchair from bathroom with the gait belt on. NA-C let go of the gait belt to secure the wheelchair and R1 fell and broke his hip. NA-C stated she should not have let go of the gait belt. NA-C explained she was placed on leave and was re-educated on safe transfers and gait belt usage prior to returning to work.<br><br>During an interview on 9/11/24 at 7:03 a.m., LPN-B stated she was working the morning R1 fell on 8/24/24. LPN-B had been passing medications when she heard a bang and R1 yelling. When she entered the room, R1 was lying in front of the door. LPN-B was under the impression R1's care plan was followed at the time of the fall based on NA-C's report that R1 had slipped when he was being walked to the bathroom. LPN-B indicated NA-C should not have let go of the gait belt until R1 was safely seated. | F 689 | | |

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| F 689 | Continued From page 3<br><br>During an interview on 9/11/24 at 12:34 p.m., director of nursing (DON) stated when he first learned about the incident he was told R1 slipped and fell. DON thought the care plan was being followed until on 8/27/24, FM-A brought in a copy of the video. Administrator and DON watched the video with family present and were able to see NA-C had let go of the gait belt and R1 falling to the floor as a result of losing his balance. After viewing the video, the facility re-educated all staff on 8/27/24, on safe transfers and expectations for using the gait belt during transfers.<br><br>Review of the facility's attestation statement "Plan of Care/Gait Belt dated 8/2024 in conjunction with the facility staff nursing roster and "Gait Belt Transfer/Ambulation Audits" indicated all staff acknowledged they received and understood education on the use of gait belt and following the care plan of residents within the facility between 8/27/24 and 9/5/24. "Staff are to check the Kardex/care plan prior to assisting residents with mobility, including transfers and/or ambulation. The Kardex/care plan includes use of gait belt for transfers/ambulation, staff are to hold on to the gait belt the entire time until the resident is safely seated on the destination surface."<br><br>Review of facility policy titles Gait-Transfer Belt, dated 5/2/24, indicated gait belts were to be used with assisted ambulation unless medically contraindicated. A gait belt was never to be used as a lifting device, only for stabilization.<br>-4. When holding the belt, an underhand grasp should be used.<br>-6. Transfer or ambulate resident and remove belt. | F 689 | | |

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| F 880 | Continued From page 4 | F 880 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; | F 880 | | 10/16/24 |

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| F 880 | Continued From page 5<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions ((EBPs), an infection control intervention designed to reduce the spread of infections which employs targeted gown and glove use during high contact resident care activities) were implemented for 2 of 2 residents (R4, R6) observed with implanted medical devices. | F 880 | 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 | |

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| F 880 | Continued From page 6<br><br>Findings include:<br><br>R4<br>R4's quarterly Minimum Data Set (MDS) dated 7/3/24, indicated R4 was dependent on staff with all activities of daily living (ADLs). R4's diagnoses included multiple sclerosis, ostomy (surgical opening for his bowels), and urinary catheter.<br><br>R4's infection care plan dated 4/5/24, indicated R4 required EPBs related to supra pubic catheter (a tube that drains urine from the bladder through a small incision in the lower abdomen) and ostomy (a surgical opening for his bowels on abdomen). Interventions directed staff to don a gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking, and changing, device care and/or use, and wound care.<br><br>During an observation on 9/10/24 at 4:56 p.m., nursing assistant (NA)-E assisted NA-M to get R4 out of bed. NA-M had on personal protective equipment (PPE) including gloves, gown, and a mask. NA-E did not have a gown or gloves on when she assisted NA-M with turning R4 over, pulling R4's pants up and placing the mechanical lift sling underneath him. Then NA-E assisted with transferring R4 out of bed to his wheelchair using the full body mechanical lift.<br><br>During an interview on 9/10/24 at 5:05 p.m., NA-E stated she should have put on gown and gloves but did not think about it, even though NA-M had on gown, gloves, and mask. NA-E stated R4 was on EBP's and supplies were stored on his door. | F 880 | 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.<br><br>F880- Infection Prevention & Control<br>1) Resident R4 is on Enhanced Barrier Precautions (EBP) due to a supra pubic catheter and an ostomy. Resident R6 is on EBP Precautions due to a urinary catheter and a feeding tube. Both residents had a review of their care plan completed by the DON on September 12, 2024, to ensure that EBP are listed so staff are aware of the precautions. The DON ensured that supplies were available for staff to utilize for EBP on September 12, 2024, and supplies and signage were appropriately available for staff. Education was provided for staff on September 11, 2024, to ensure that EBP is being followed for the residents listed.<br>2) All residents have the potential to be affected by the deficient practice. Specifically, residents with the need to have Enhanced Barrier precautions. The DON did a review of care plans for all residents September 12 through September 18 to ensure that EBP was listed appropriately on all residents who need EBP. Supplies were checked to ensure that they were readily available for staff to use, and all supplies were well stocked on September 11, 2024 to ensure that EBP can be properly followed for all residents who are required to have these | |

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| F 880 | Continued From page 7<br><br>R6<br>R6's quarterly MDS dated 7/3/24, indicated R6 had an indwelling urinary catheter and a feeding tube (tubes mainly inserted into the gastrointestinal (GI) tract to provide a patient with a route for enteral nutrition). R6 required partial to substantial assistance from staff with his ADLs.<br><br>R6's infection care plan dated 4/5/24, indicated R6 required EBPs related to indwelling catheter. Interventions directed Staff to don a gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking, and changing, device care and/or use, and wound care. R6's care plan failed to identify a need for EBP's with G-tube (gastrostomy tube, a type of feeding tube) care and the administration of medications via G-tube.<br><br>During an observation on 9/11/24 at 10:10 a.m., licensed practical nurse (LPN)-D entered R6's room without putting a gown on and used hand sanitizer but did not put on gloves. LPN-D turned off R6's tube feeding pump and disconnected the tubing from R6's feeding port. LPN-D prepared R6's medications to administer via feeding tube then put gloves on prior to administering them.<br><br>During an interview on 9/11/24 at 2:09 p.m., LPN-D stated she did not know she needed to wear a gown while administering medications via G-tube. LPN-D indicated she was not aware EBP's were necessary when administering medications through a feeding tube.<br><br>During an interview with the director of nursing | F 880 | precautions in place.<br>3) To ensure systemic changes are sustained education was provided to all nursing staff who have close interactions with residents who need EBP on October 15, 2024 through an all staff meeting. The policy Standard and Transmission Based Precautions was used to educate the staff through a PowerPoint presentation with a questions and answer session to follow to ensure understanding of the education provided.<br>4) The corrective actions will be monitored to ensure that the deficient practice will not recur via auditing of Enhanced Barrier Precautions. The DNS or designee will audit the Enhanced Barrier Precaution care plan, utilization of EBP, and supplies twice a week for four weeks and then once a week for eight weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained.<br>5) The date of correction for this will be October 16, 2024 and will be ensured by the DNS. | |

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| F 880 | Continued From page 8<br>(DON) on 9/11/24 at 12:14 p.m., the DON stated it was his expectation that PPE be worn by all staff when indicated. DON reviewed the facility policy and confirmed the medications through the G-tube would require PPE to be worn as the contents of the g-tube or stomach could come back out of the G-tube and get on staff or resident.<br><br>Review of facility policy titled Standard and Transmission-Based Precautions, dated 4/2/24 indicated the following:<br>-Enhanced barrier precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high- contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.<br>-Enhanced barrier Precautions are needed for residents with chronic wounds (Pressure Ulcers, Diabetic Foot Ulcers, Unhealed surgical wounds, and venous statis ulcers) and Residents with Indwelling Medical devices (central lines, hemodialysis catheters, indwelling urinary catheters, feeding tubes, and tracheotomies).<br>-High-Contact Resident Care Activities include transfers, dressing, assisting during bathing, providing hygiene, changing briefs, or assisting with toileting, working with resident in therapy gym, specifically when anticipating close physician contact while assisting with transfers and mobility, changing linens, device care or use (central line, urinary catheter, feeding tube, tracheostomy), and wound care. | F 880 | | |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 9/10/24 and 9/11/24, 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>The following complaints were reviewed: H54417791C (MN00106296, MN00106356) with a licensing order issued at 1390.<br>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.<br><br>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. | 2 000 | | |

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| 2 000 | Continued From page 2<br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. | 2 000 | | |
| 21390 | MN Rule 4658.0800 Subp. 4 A-I Infection Control<br><br>Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following:<br>A. surveillance based on systematic data collection to identify nosocomial infections in residents;<br>B. a system for detection, investigation, and control of outbreaks of infectious diseases;<br>C. isolation and precautions systems to reduce risk of transmission of infectious agents;<br>D. in-service education in infection prevention and control;<br>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;<br>F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;<br>G. a system for reviewing antibiotic use;<br>H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and<br>I. methods for maintaining awareness of current standards of practice in infection control.<br><br>This MN Requirement is not met as evidenced | 21390 | | 10/16/24 |

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| | 00131 | A. BUILDING: _____ B. WING _____ | C 09/11/2024 |

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| GOOD SAMARITAN SOCIETY - ALBERT LEA | 75507 240TH STREET ALBERT LEA, MN 56007 |

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| 21390 | Continued From page 3<br>by:<br>Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions ((EBPs), an infection control intervention designed to reduce the spread of infections which employs targeted gown and glove use during high contact resident care activities) were implemented for 2 of 2 residents (R4, R6) observed with implanted medical devices.<br><br>Findings include:<br><br>R4<br>R4's quarterly Minimum Data Set (MDS) dated 7/3/24, indicated R4 was dependent on staff with all activities of daily living (ADLs). R4's diagnoses included multiple sclerosis, ostomy (surgical opening for his bowels), and urinary catheter.<br><br>R4's infection care plan dated 4/5/24, indicated R4 required EPBs related to supra pubic catheter (a tube that drains urine from the bladder through a small incision in the lower abdomen) and ostomy (a surgical opening for his bowels on abdomen). Interventions directed staff to don a gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking, and changing, device care and/or use, and wound care.<br><br>During an observation on 9/10/24 at 4:56 p.m., nursing assistant (NA)-E assisted NA-M to get R4 out of bed. NA-M had on personal protective equipment (PPE) including gloves, gown, and a mask. NA-E went to the window side of the bed and assisted with turning R4 over, pulling pant up and placing the hoyer sling under him. Then | 21390 | Corrected | |

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| 21390 | Continued From page 4<br><br>assisted with the transfer with hoyer lift of R4 from bed to his broda chair. NA-E did not have on any PPE and was not wearing a gown and gloves as directed by R4's care plan.<br><br>During an interview on 9/10/24 at 5:05 p.m., NA-E stated she should have put on PPE of gown and gloves but did not think about it, even though NA-M had on gown, gloves, and mask. NA-E was able to state that R4 was on EBP's and supplies were stored on his door.<br><br>R6<br>R6's quarterly MDS dated 7/3/24, indicated R6 had an indwelling urinary catheter and a feeding tube (tubes mainly inserted into the gastrointestinal (GI) tract to provide a patient with a route for enteral nutrition). R6 required partial to substantial assistance from staff with his ADLs.<br><br>R6's infection care plan dated 4/5/24, indicated R6 required EBPs related to indwelling catheter. Interventions directed Staff to don a gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking, and changing, device care and/or use, and wound care. R6's care plan failed to identify a need for EBP's with G-tube (gastrostomy tube, a type of feeding tube) care and the administration of medications via G-tube.<br><br>During an observation on 9/11/24 at 10:10 a.m., licensed practical nurse (LPN)-D entered R6's room. R6's tube feeding was running through an automated pump. LPN-D performed hand hygiene upon entering R6's room with hand sanitizer, shut off the tube feeding and disconnected the tube feeding line from R6's | 21390 | | |

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| 21390 | Continued From page 5<br><br>G-tube without gloves, gown, or mask on. LPN-D continued to get R6's medications ready for administration via G-tube without gloves on. LPN-D finished crushing medications and poured the liquid medication into a medication cup. LPN-D then applied gloves and verified the G-tube's placement by injecting air, listening with a stethoscope, and aspirating contents and administered the medications via G-tube.<br><br>During an interview on 9/11/24 at 2:09 p.m., LPN-D stated she did not know she needed to wear PPE while administering medications via G-tube. LPN-D stated with residents on EBP's, the information she could remember was if giving medications did not have to wear EBP's unless administering a nebulizer.<br><br>During an interview with the director of nursing (DON) on 9/11/24 at 12:14 p.m., the DON stated it was his expectation that PPE be worn by all staff when indicated. DON stated it was his understanding the EBP's were not needed for medication administration. After discussion and reviewing the facility policy DON agreed that medications through the G-tube would require PPE to be worn as the contents of the g-tube or stomach could come back out of the G-tube and get on staff or resident.<br><br>Review of facility policy titled Standard and Transmission-Based Precautions, dated 4/2/24 indicated the following:<br>-Enhanced barrier precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high- contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.<br>-Enhanced barrier Precautions are needed for | 21390 | | |

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| 21390 | Continued From page 6<br><br>residents with chronic wounds (Pressure Ulcers, Diabetic Foot Ulcers, Unhealed surgical wounds, and venous statis ulcers) and Residents with Indwelling Medical devices (central lines, hemodialysis catheters, indwelling urinary catheters, feeding tubes, and tracheostomies).<br>-High-Contact Resident Care Activities include transfers, dressing, assisting during bathing, providing hygiene, changing briefs, or assisting with toileting, working with resident in therapy gym, specifically when anticipating close physician contact while assisting with transfers and mobility, changing linens, device care or use (central line, urinary catheter, feeding tube, tracheostomy), and wound care.<br><br>SUGGESTED METHO OF CORRECTION: The Director of Nursing (DON), ICP, or designee 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. 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 g-tube feeding/medication administration 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.<br><br>TIME PERIOD FOR CORRECTION: 21 | 21390 | | |

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| 21390 | Continued From page 7<br>(twenty-one) DAYS | 21390 | | |