Electronically delivered
January 26, 2021

Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, MN 56401

RE: CCN: 245500
Cycle Start Date: January 11, 2021

Dear Administrator:

On January 11, 2021, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 10, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 10, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 10, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 10, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Bethany will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 10, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 11, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and

1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	**804 WRIGHT STREET BRAINERD, MN 56401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/7/21, through 1/11/21, an abbreviated survey was completed at your facility to conduct a complaint(s) investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5500093C (MN68683) with deficiencies cited at F580, F660 and F684. H5500094C (MN68746) with deficiencies cited at F580, F660 and F684. H5500090C (MN57718 and MN57582) with no deficiencies cited due to actions taken by the facility prior to survey entrance. In addition, the following complaints were found to be unsubstantiated: H5500091C (MN64226) H5500092C (MN67541) 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. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		2/8/21

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

Electronically Signed | 02/04/2021

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
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	**804 WRIGHT STREET BRAINERD, MN 56401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician and family of a change of condition for 1 of 3 residents (R1) reviewed who were discharged. This resulted in actual harm for R1 who was discharged to a lower level of care and subsequently transferred to the hospital the day of discharge, where R1 expired. Findings include: R1's undated, Admission Record indicated he admitted to the facility with diagnoses which included emphysema and chronic obstructive pulmonary disease (COPD). R1's admission Minimum Data Set (MDS) dated 11/24/20, indicated he had moderate cognitive impairment and required extensive assistance from two staff for activities of daily living. The MDS indicated R1 displayed no behaviors and had not received oxygen therapy prior to or since admission to the facility. A physician Nursing Home Note dated 12/22/20, indicated R1 was seen via video visit by medical doctor (MD)-A. The note indicated at times R1 complained of dizziness and shortness of breath	F 580	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. Resident R1 was the only resident found to be effected and had discharged from facility prior to survey All residents are at risk to not have a change in condition reported to family and physician. A file review of all residents will be conducted by DNS and/or designees looking for any changes in condition in the last 14 days and ensuring that any found were reported to the family and physician.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 believed to be related to chronic atrial fibrillation. The note further identified a diagnosis of COPD and indicated R1 had no "clear cut" exacerbations, O2 readings have remained in a good range." Staff asked about potential for use of O2 for shortness of breath but because saturation levels had not dropped it was determined O2 was not needed at that time. There was no evidence of COPD exacerbation. An addendum to the note, undated, indicated R1 had COPD and was O2 dependent. Saturation levels ran in the 85-90% range. The MD provided a recommendation for R1 to be on O2 around the clock (continuous) to maintain O2 levels at or above 90%. A facility Progress Note dated 12/27/20, indicated R1's oxygen (O2) saturation was 60 - 70 % [average 90-100%] on room air. R1 had thick brown phlegm in his throat, he was coughing up and was placed on 2 liters of O2 with no improvement in O2 sats after four minutes. O2 was increased to 6 liters to maintain saturation levels of 89 - 91%. R1 coughed up large amounts of brown, sticky phlegm for about 45 minutes. Lung sounds were diminished but clear. After coughing R1 was able to maintain O2 levels above 95% on 2 liters O2. R1's O2 Saturation Summary indicated on 12/29/20, R1 had a saturation level of 71% on room air at 7:00 a.m. No further O2 levels were documented until 10:00 p.m. when R1's O2 saturation level was 89% while O2. R1's Progress Note dated 12/30/20, indicated R1 was holding saliva in his mouth and would not swallow. The nurse attempted to suction R1 with no results. R1 had faint crackles in bases of	F 580	All licensed nursing staff are required to notify family and physician of changes in condition as per policy. All licensed nursing staff were re-educated on the policy and requirement to report all changes in condition to family and physician during the education sessions on 2/3/2021-2/5/2021 conducted by DNS and designees. Additionally IDT morning meeting structure was changed to review EMAR weight and vitals dashboard and all triggers caused by abnormalities, and ensure they are being reported to resident□s family and physician. Audits will be conducted by DNS and/or designees of 3 different residents 3 times a week for 6 weeks to ensure that any changes in condition found in progress notes or indicated by changes in vitals were followed by notification of family and physician. Results to be reported to QAPI committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4	F 580		

lungs.

A PT (physical therapy) Daily Treatment Note dated 12/30/20, indicated the therapist notified a nurse and nurse manager, about O2 saturation levels in the 70's on three liters of supplemental oxygen. The therapist increased R1's oxygen to 4-5 liters. R1's saturation levels only increased to 80%.

R1's Progress Note dated 12/30/20, indicated R1 was seen by nurse practitioner (NP)-A by telehealth video. The facility nurse had reported abnormal lung sounds, deterioration of condition and requested orders for O2 and a wheel chair. A Documentation of Face to Face Encounter for Medicare Clients dated 12/30/20, written by NP-A indicated R1 was seen for a wheel chair and home oxygen. The note indicated R1 required as needed O2 to keep saturation levels above 88%. The encounter note indicated a diagnosis of emphysema; however, did not include an assessment of R1's lung condition.

R1's Progress Note dated 12/30/20, identified R1 was resting in bed until being assisted into a wheel chair at 3:30 p.m. R1 was restless but weak, audible tracheal gurgling heard. R1 was encouraged to cough and deep breathe and able to clear. O2 was on at 2 liters. Resident was brought to the front entry. After R1 was brought to the entrance and was outside, writer returned to the unit.

R1's Discharge Summary dated 12/30/20, identified a health conditions of "COPD O2 sats [saturation] drop." However, the summary did not identify R1's current lung condition status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	**804 WRIGHT STREET BRAINERD, MN 56401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5	F 580		

An untitled hospital record dated 12/30/20, indicated upon arrival to the emergency room R1's blood pressure was 57/40 [average range 120/80 - 140/90]. The note indicated he was ill-appearing and looked toxic, vitals were not stable and he was unresponsive. The notes indicated R1 was in septic shock from presumed bacterial pneumonia and had severe, life threatening lactic acidosis (lactic acid is a substance that can build up in your body if you are not getting enough oxygen). The notes identified evidence or organ damage due to severe sepsis (infection in the blood) including acute respiratory failure, hypoxia (a decreased level of oxygen in all or part of your body) and hypercapnia (too much carbon dioxide in your bloodstream).

On 1/7/21, at 1:34 p.m. the assisted living facility (ALF) RN stated when R1 arrived at the ALF he was not very responsive. The ALF RN stated when she completed the admission assessment she reviewed the discharge documentation from the facility and it did not include an assessment or documentation of R1's condition when he left the facility so she had no baseline for him. The ALF RN stated R1's initial blood pressure was low, his heart rate was in the 40's [average range 60-100] and O2 saturation was in the high 80's. She stated later in the evening staff rechecked R1's vitals and his blood pressure was 50's/30's, O2 was in the 70's and staff were unable to detect a pulse on their equipment. R1 was then sent to the emergency room for further evaluation and passed away the next day.

During interview on 1/7/21, at 3:39 p.m. NP-A stated she had seen R1 via video on 12/30/20, his condition had deteriorated since she last saw

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	**804 WRIGHT STREET BRAINERD, MN 56401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6	F 580		

him on 12/7/20. NP-A reviewed R1's medical record and identified he was seen by NP-B on 12/23/20, and did not have an O2 order at that time. When asked about the face to face visit related to the O2 order on 12/30/20, NP-A stated the facility had called her on 12/30/20, and she was unable to complete the visit until later in the day so the facility called MD-A who then amended his note from the 12/22/20, visit. NP-A stated the order for the O2 was written by MD-A before she saw R1. Further, NP-A indicated she only saw R1 to fulfill a Medicare requirement for the face to face and did not identify she completed an actual assessment of R1's lung status.

During interview on 1/8/21 at 8:57 a.m. registered nurse (RN)-A who was the unit nurse manager, stated, "I think his sats [saturation levels] dropped the Sunday before he discharged." RN-A stated MD-A and NP-A were both notified when R1 began to decline; however she had notified the medical providers only about R1's repeated falls. When asked about R1's overall decline, RN-A stated she did not think any medical interventions were implemented and stated RN-A stated she talked to MD-A and NP-A about the need for oxygen upon discharge from the facility, but stated she had not updated them regarding the saturation levels dropping into the 70% range and was not sure if any of the nurses had called and updated R1's medical providers. Further, the addendum on the physician's note dated 12/22/20, was added on 12/30/20, following her request for O2.

At 9:32 a.m. family member (FM)- A stated the facility had not contacted them and told them R1 needed O2. FM-A stated when R1 arrived at the assisted living facility his blood pressure was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	**804 WRIGHT STREET BRAINERD, MN 56401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7	F 580		

really, really low and he was sent to the emergency department. FM-A stated R1 was admitted to the intensive care unit and died from double pneumonia, organ failure and sepsis.

At approximately 10:00 a.m. physical therapist (PT)-A stated the day R1 discharged from the facility he had worked with R1 and R1's O2 saturation had dropped to 70% on two liters of O2. PT-A stated he reported it to the nurse on the floor who said RN-A was aware and they had been in contact with the physician. PT-A said the way it was communicated to him he thought it was something that was continually being monitored.

At 10:20 a.m. NP-B stated she had last seen R1 on 12/23/20, due to his multiple falls. NP-B stated she went on vacation and when she returned R1 had died. NP-B stated R1 had not required the use of O2 and his vitals signs had been stable. NP-B stated, "honestly, I don't believe anyone was notified of the change of condition" for R1.

At 11:29 a.m. MD-A stated on 12/30/20, he was trying to arrange for durable medical equipment for R1's discharge and had been speaking with RN-A. MD-A did not complete a face to face evaluation as MD-A stated he had not been aware of the decreased O2 saturation level. Further, if he was made aware of the change in R1's condition he would not have okayed him for discharge to the assisted living and would have sent R1 to the emergency department for further evaluation.

On 1/11/21, at 10:48 a.m. the DON stated R1 had been declining throughout his stay at the facility however, she she would have expected staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 8 let the physician know of the decline in lung status and staff should have reported the saturation levels in the 70's. A facility policy related to notification of change of condition was requested but none received.	F 580		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and	F 660		2/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 9	F 660		

resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 10 information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to facilitate a safe and effective discharge plan for 1 of 3 residents (R1) reviewed who discharged to a lower level of care. Findings include: R1's admission Minimum Data Set (MDS) dated 11/24/20, indicated he had moderate cognitive impairment and required extensive assistance from two staff for activities of daily living. The MDS indicated R1 displayed no behaviors and had not received oxygen therapy prior to or since admission to the facility. The MDS further indicated R1 had not sustained any falls since admission to the facility. R1's care plan dated 11/27/20, identified a self performance deficit related to weakness, impaired mobility and deconditioning. The care plan directed staff to provide assistance of one staff to complete bathing, toileting and personal hygiene needs. The care plan identified assitance from one staff for transfers using a walker unless he displayed behaviors then provide assistance of two staff. The care plan identified a risk for falls related to frequent falls, multiple medications and impaired cognition. The care plan directed staff to remind R1 not to bend over and pick up items, encourage activities, ensure proper foot wear, assistance of one staff and a walker to and from the bathroom and physical therapy for strength and mobility.	F 660	Resident R1 was the only resident found to be effected and had discharged from facility prior to survey All residents are at risk to not have a change in condition monitored and/or assessed. A file review of all residents will be conducted by DNS and/or designees looking for any changes in condition in the last 14 days and ensuring that any found are/were being monitored and assessed. All licensed nursing staff are required to monitored and/or assessed changes in condition as per policy. All licensed nursing staff were re-educated on the policy and requirement to monitor and/or assess all changes in condition during the education sessions on 2/3/2021-2/5/2021 conducted by DNS and designees. Additionally IDT morning meeting structure was changed to review EMAR weight and vitals dashboard and all triggers caused by abnormalities and assure that they are being monitored and/or assessed. Audits will be conducted by DNS and/or designees of 3 different residents 3 times a week for 6 weeks to ensure that any changes in condition found in progress notes or indicated by changes in vitals were followed by monitoring and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 11 A Common Entry Intake Form dated 12/31/20, indicated R1 was discharged from the facility in unstable condition resulting in a hospitalization shortly after arrival to the assisted living facility (ALF). The report indicated the communication between the discharging facility and the ALF was "subpar" and did not include significant changes in condition. The report indicated provider notes sent to the ALF did not indicate awareness of changes and did not include supporting documentation of the need for oxygen. R1 arrived at the ALF quite ill and was sent to the emergency room where he was diagnosed with pneumonia and sepsis and placed on life support. The report indicated the ALF RN had spoken to the discharging facility multiple times the week prior to discharge as well as the day of discharge and the facility did not communicate the severity of R1's overall well-being. The report further indicated the facility notified the ALF of the physician's recommendation for hospice only after R1 had discharged from the facility. A Physical therapist (PT) Therapist Progress and Discharge Summary dated 12/9/20, indicated R1 ambulated with partial/moderate assistance 175 feet on level surfaces. The summary indicated R1 was able to transfer from sitting to standing with variable assistance from contact guard to max assist of two staff. Recommendation was stand pivot assist of two staff for safety. The summary further indicated R1 did not make significant progress toward goals due to cognition, at times was able to complete bed mobility, transfers and walking with contact guard assist but at other times due to agitation and inability to communicate needs required up to maximum assistance. Recommendation for two staff for	F 660	assessment. Results to be reported to QAPI committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 12	F 660		

transfers for safety.

Physical therapist (PT) Therapist Progress and Discharge Summary dated 12/30/20, indicated R1 was fully dependent on staff for transfers using a mechanical lift and did not ambulate. The summary indicated R1's declining cognition and health had impacted his ability to participate with bed mobility, transfers and ambulation. R1 was dependent on mechanical lift for transfers and was no longer appropriate to attempt to stand or ambulate.

An undated facility document Accounting of Disclosures Log indicated the following items were sent to the ALF on 12/22/20: Face Sheet, Care Plan, Nursing Notes, Medication review, History and Physical, Immunizations, Providers Order for Life Sustaining Treatment and Progress Note(s). There was no evidence the facility provided the ALF with updated information even though R1 had a decline in function and change in health status.

R1's care plan, sent to the ALF, on the day he admitted to the ALF (12/30/21) was dated 11/18/20, and indicated R1 required assistance from one staff for bed mobility, dressing, toileting and transfers and identified a risk for falls.

R1's Discharge Summary dated 12/30/20, indicated his hearing and vision were adequate, he was unable to consistently use his call light and he was very confused and knew self and family and that he was not at his home. The summary indicated he would ask for something like toileting then refuse saying he didn't ask for that, insisted on trying to stand on his own but was weak and fell frequently. The Discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 13	F 660		

Summary further indicated R1 was dependent on staff for dressing, grooming, bathing, toileting and mobility but did not identify level of dependence. Health conditions indicated oxygen saturation levels dropped.

During interview on 1/7/20, at 1:34 p.m. the ALF registered nurse (RN) stated When R1 arrived at the ALF he was not very responsive and not answering questions. She was told he could answer yes or no questions. When R1 was brought to his room he required two staff to transfer him and he was not bearing any weight and she had been told he was ambulatory with a walker using two staff only for safety, not for physical need was independent with bed mobility and could transfer to the bath with one staff. While completing the admission assessment there were no notes related to R1's condition upon discharge from the facility. The ALF RN stated the facility had told her R1 had some dementia and some behaviors that included yelling for help and wanting attention and also that R1 would get resistive at times. The facility had reported R1 had slid out of bed and had not had any injuries but stated she had not been aware of how many falls R1 had until family told her he had fallen at least 15 times since admission. She was told he was on safety checks and if she had known how many falls R1 had she would not have accepted him for admission the the ALF. Prior to admission she had received a medication sheet, list of diagnosis and a note from the physician about a rash and starting Zyprexa. The facility had called the day of R1's discharge and spoke to staff and told them they had to use a mechanical lift to get him into the wheel chair. She stated afterward she called the facility and was told R1 was on his way and in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 14	F 660		

regard to the use of the lift and stated the facility "had not" reported he was transferring with a mechanical lift and not an assist of two as reported previously. Further she asked the facility if the physician had been notified of the change in R1's condition and was told the physician had recommended hospice. The ALF RN stated the physicians note she received had no indication there was a need for hospice.

On 1/8/20, at 5:57 a.m. RN-A stated when R1 came to her unit he was able to stand and walked with a walker but quickly went "downhill." RN-A stated a couple days before he discharged therapy had recommended the use of a mechanical lift. RN-A stated before R1 discharged form the facility she had told the ALF she did not think he was appropriate for assisted living and said she told the nurse he was using a lift and was a high fall risk.

During interview at approximately 10:00 a.m. physical therapist (PT)-A stated after R1 moved from the transitional care unit (TCU) to station two it seemed as though he declined in cognition and medically. PT-A stated, "I did not think he was appropriate for assisted living."

At 10:20 a.m. nurse practitioner (NP)-B stated the last time she had seen R1 she had questioned the appropriateness of an assisted living and documented in her progress note. A correlating progress note written by NP-B dated 12/23/20, indicated family planned to move R1 to an assisted living in the coming weeks and NP-B was concerned with his behaviors he would be unstable there.

At 11:29 a.m. medical doctor (MD)-A stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 15 main issue with R1 was his behaviors and the fact R1 had not been eating or drinking. MD-A stated if he had been aware of the change in R1's lung status or he would have had the facility transfer him to the hospital for evaluation. He would not signed have signed off on discharging R1 to the assisted living facility. The facility policy Discharge Planning Rehab/Skilled Nursing dated 12/22/20, indicated when creating a discharge plan it was important to be comprehensive, to address all of the residents needs. If a resident wishes to be discharged to a setting that does not meet his/her needs document the discussion of the risks of being discharged to this setting.	F 660		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to assess and monitor a change in lung condition for 1 of 3 residents (R1) reviewed for a change of condition. This resulted in actual harm for R1 who was discharged to a lower level of care and subsequently transferred to the hospital the day of discharge, where R1 expired.	F 684	Resident R1 was the only resident found to be effected and had discharged from facility prior to survey All residents are at risk to not have a change in condition monitored and/or assessed. A file review of all residents will be conducted by DNS and/or designees	2/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16 Findings include: R1's undated, Admission Record indicated R1 admitted to the facility with diagnoses that included emphysema and chronic obstructive pulmonary disease (COPD). R1's admission Minimum Data Set (MDS) dated 11/24/20, indicated he had moderate cognitive impairment and required extensive assistance from two staff for activities of daily living. The MDS indicated R1 had not received oxygen therapy prior to or since admission to the facility. R1's care plan dated 11/27/20, identified a self performance deficit related to weakness, impaired mobility and deconditioning. The care plan directed staff to provide assistance of one staff to complete bathing, toileting and personal hygiene needs. The care plan lacked nursing interventions related to assessment or monitoring R1's COPD. R1's Oxygen (O2) Saturation Summary dated 11/18/20 - 12/30/20, indicated R1 did not use supplemental O2 from 11/18/20 to 12/27/20. The summary indicated on 12/27/20, R1's saturation levels were maintained at 89 - 98 % on room air [average range 90%-100%], without the need for supplemental O2. A physician Nursing Home Note dated 12/22/20, indicated R1 was seen via video visit by medical doctor (MD)-A. The note indicated at times R1 complained of dizziness and shortness of breath believed to be related to chronic atrial fibrillation. The note further identified a diagnosis of COPD and indicated R1 had no "clear cut" exacerbations, O2 readings have remained in a	F 684	looking for any changes in condition in the last 14 days and ensuring that any found are/were being monitored and assessed. All licensed nursing staff are required to monitored and/or assessed changes in condition as per policy. All licensed nursing staff were re-educated on the policy and requirement to monitor and/or assess all changes in condition during the education sessions on 2/3/2021-2/5/2021 conducted by DNS and designees. Additionally IDT morning meeting structure was changed to review EMAR weight and vitals dashboard and all triggers caused by abnormalities and assure that they are being monitored and/or assessed. Audits will be conducted by DNS and/or designees of 3 different residents 3 times a week for 6 weeks to ensure that any changes in condition found in progress notes or indicated by changes in vitals were followed by monitoring and/or assessment. Results to be reported to QAPI committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17	F 684		

good range." Staff asked about potential for use of O2 for shortness of breath but because saturation levels had not dropped it was determined O2 was not needed at that time. There was no evidence of COPD exacerbation. An addendum to the note, undated, indicated R1 had COPD and was O2 dependent. Saturation levels ran in the 85-90% range. The MD provided a recommendation for R1 to be on O2 around the clock (continuous) to maintain O2 levels at or above 90%.

A facility Progress Note dated 12/27/20, indicated R1's oxygen (O2) saturation was 60 - 70% on room air. R1 had thick brown phlegm in his throat, he was coughing up and was placed on 2 liters of O2 with no improvement in O2 sats after four minutes. O2 was increased to 6 liters to maintain saturation levels of 89 - 91%. R1 coughed up large amounts of brown, sticky phlegm for about 45 minutes. Lung sounds were diminished but clear. After coughing R1 was able to maintain O2 levels above 95% on 2 liters O2. The medical record lacked further assessment of R1's symptoms.

R1's O2 Saturation Summary indicated on 12/29/20, R1 had a saturation level of 71% on room air at 7:00 a.m. No further O2 levels were documented until 10:00 p.m. when R1's O2 saturation level was 89% while O2. The medical record lacked evidence of ongoing monitoring or further assessment.

R1's Progress Note dated 12/30/20, indicated R1 was holding saliva in his mouth and would not swallow. The nurse attempted to suction R1 with no results. R1 had faint crackles in bases of lungs. No further assessment was identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18	F 684		

A PT (physical therapy) Daily Treatment Note dated 12/30/20, indicated the therapist notified a nurse and nurse manager about R1 having O2 saturation levels in the 70's on three liters of supplemental oxygen during therapy. The therapist had increased R1's oxygen to 4-5 liters. R1's saturation levels only increased to 80%.

R1's Progress Note dated 12/30/20, indicated R1 was seen by nurse practitioner (NP)-A by telehealth video. The note indicated the facility nurse reported abnormal lung sounds, deterioration of condition and requested orders for O2 and a wheel chair. The note was written by registered nurse (RN)-A.

R1's Progress Note dated 12/30/20, indicated R1 was resting in bed until being assisted into a wheel chair at 3:30 p.m. R1 was restless but weak, audible tracheal gurgling was heard. R1 was encouraged to cough and deep breathe and able to clear. O2 was on at 2 liters. R1 was brought to the front entry and outside at which point the writer returned to the unit. The medical record again lacked evidence of further assessment or physician notification prior to discharging R1 from the facility.

R1's Discharge Summary dated 12/30/20, identified a health conditions of "COPD O2 sats [saturation] drop." However, the summary did not identify R1's current lung condition status or any further assessment of R1's lung condition.

An untitled hospital record dated 12/30/20, indicated upon arrival to the emergency room R1's blood pressure was 57/40 [average range 120/80 - 140/90]. The note indicated he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19	F 684		

ill-appearing and looked toxic, vitals were not stable and he was unresponsive. The notes indicated R1 was in septic shock from presumed bacterial pneumonia and had severe, life threatening lactic acidosis (lactic acid is a substance that can build up in your body if you are not getting enough oxygen). The notes identified evidence or organ damage due to severe sepsis (infection in the blood) including acute respiratory failure, hypoxia (a decreased level of oxygen in all or part of your body) and hypercapnia (too much carbon dioxide in your bloodstream).

On 1/7/21, at 1:34 p.m. the assisted living facility (ALF) RN stated when R1 arrived at the ALF he was not very responsive. The ALF RN stated when she completed the admission assessment she reviewed the discharge documentation from the facility and it did not include an assessment or documentation of R1's condition when he left the facility so she had no baseline for him. The ALF RN stated R1's initial blood pressure was low, his heart rate was in the 40's [average range 60-100] and O2 saturation was in the high 80's. She stated later in the evening staff rechecked R1's vitals and his blood pressure was 50's /30's, O2 was in the 70's and staff were unable to detect a pulse on their equipment. R1 was then sent to the emergency room for further evaluation and passed away the next day.

During interview on 1/7/21, at 3:39 p.m. NP-A stated she had seen R1 via video on 12/30/20, his condition had deteriorated since she last saw him on 12/7/20. NP-A reviewed R1's medical record and identified he was seen by NP-B on 12/23/20, and did not have an O2 order at that time. When asked about the face to face visit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 20	F 684		

related to the O2 order on 12/30/20, NP-A stated the facility had called her on 12/30/20, and she was unable to complete the visit until later in the day so the facility called MD-A who then amended his note from the 12/22/20, visit. NP-A stated the order for the O2 was written by MD-A before she saw R1. Further, NP-A indicated she only saw R1 to fulfill a Medicare requirement for the face to face and did not identify she completed an actual assessment of R1's lung status.

During interview on 1/8/21, at 8:26 a.m. nursing assistant (NA)-A stated R1 did not always use oxygen and stated the O2 use had started only a few days before he discharged.

At 8:57 a.m. RN-A, the unit manager, stated R1 had not used oxygen when he came to the unit and stated, "I think his sats [saturation levels] dropped the Sunday before he discharged." RN-A stated she talked to MD-A and NP-A about the need for oxygen upon discharge from the facility, but stated she had not updated them regarding the saturation levels dropping into the 70 % range and was not sure if any of the nurses had called and updated R1's medical providers. RN-A did not identify why she did not discuss R1's dropping O2 saturations with MD-A. Further, the addendum on the physician's note dated 12/22/20, was added on 12/30/20, following her request for O2.

At 9:32 a.m. family member (FM)- A stated the facility had not contacted them and told them R1 needed O2. FM-A stated when R1 arrived at the assisted living facility his blood pressure was really, really low and he was sent to the emergency department. FM-A stated R1 was admitted to the intensive care unit and died from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 21	F 684		

double pneumonia, organ failure and sepsis.

At approximately 10:00 a.m. physical therapist (PT)-A stated the day R1 discharged from the facility he had worked with R1 and R1's O2 saturation had dropped to 70% on two liters of O2. PT-A stated he reported it to the nurse on the floor who said RN-A was aware and they had been in contact with the physician. PT-A said the way it was communicated to him he thought it was something that was continually being monitored.

At 10:20 a.m. NP-B stated she had last seen R1 on 12/23/20, due to his multiple falls and was not related to R1's lung status. NP-B stated she went on vacation and when she returned R1 had died. NP-B stated at the time of her last visit R1 had not required the use of O2 and his vitals signs had been stable. NP-B stated, "honestly, I don't believe anyone was notified of the change of condition" for R1's lung status.

At 11:29 a.m. MD-A stated on 12/30/20, he was trying to arrange for durable medical equipment for R1's discharge and had been speaking with RN-A. MD-A did not complete a face to face evaluation as MD-A stated he had not been aware of the decreased O2 saturation level. Further, if he was made aware in the change in R1's lung condition he would not have okayed him for discharge to assisted living and would have sent R1 to the emergency department for further evaluation.

On 1/11/21, at 10:48 a.m. the director of nursing (DON) stated R1 had been declining throughout his stay at the facility. The DON stated over the weekend prior to his discharge he was requiring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 22	F 684		

O2 when he couldn't clear his mucous but it was "periodic." The DON stated R1 did not display a drastic change in his vital signs and his O2 saturations levels were not real low. She stated she felt it was "just a slow decline." The DON stated she was aware the day of discharge they were evaluating R1's need for O2 and said the reports she received was R1 was doing what he had been doing for weeks and was regularly using O2. The DON stated "It was a slow and consistent decline in my opinion," but stated she would have expected staff to report the saturation levels in the 70's and to let the physician know of the decline.

The facility policy Change In Condition Evaluation - CICE dated 12/11/20, directed staff to begin the CICE and collect pertinent clinical data prior to contacting the physician when a resident experienced a change of condition and continue to monitor the resident and update the CICE evaluation as appropriate. Upon completion of the evaluation, a notification hyperlink will turn red if there is information that needs to be communicated to the provider.

R1's medical record lacked a CICE form related to a change in condition in lung status.

Electronically delivered
January 26, 2021

Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, MN 56401

Re: State Nursing Home Licensing Orders
Event ID: NJ9U11

Dear Administrator:

The above facility was surveyed on January 7, 2021 through January 11, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF

CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/7/21, through 1/11/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaints were found to be substantiated: H5500093C (MN68683) with licensing orders issued at MN Rule 4658.0085 subd. 0265, 4658.0520 Subp.B 0830 H5500094C (MN68746) with licensing orders issued at MN Rule 4658.0085 subd. 0265 H5500090C (MN57718 and MN57582) , no licensing orders were issued due to actions taken by the facility prior to survey entrance. The following complaints were found to be unsubstantiated and no licensing orders were issued: H5500091C (MN64226) H5500092C (MN67541) The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. 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 surveyors findings are the Suggested Method of Correction and Time period for Correction.	2 000	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 surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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. 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.	2 000	VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must	2 265		2/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 3 have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to notify the physician and family of a change of condition for 1 of 3 residents (R1) reviewed who were discharged. This resulted in actual harm for R1 who was discharged to a lower level of care and subsequently transferred to the hospital the day of discharge, where R1 expired. Findings include: R1's undated, Admission Record indicated he admitted to the facility with diagnoses which included emphysema and chronic obstructive	2 265	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 4	2 265		

pulmonary disease (COPD).

R1's admission Minimum Data Set (MDS) dated 11/24/20, indicated he had moderate cognitive impairment and required extensive assistance from two staff for activities of daily living. The MDS indicated R1 displayed no behaviors and had not received oxygen therapy prior to or since admission to the facility.

A physician Nursing Home Note dated 12/22/20, indicated R1 was seen via video visit by medical doctor (MD)-A. The note indicated at times R1 complained of dizziness and shortness of breath believed to be related to chronic atrial fibrillation. The note further identified a diagnosis of COPD and indicated R1 had no "clear cut" exacerbations, O2 readings have remained in a good range." Staff asked about potential for use of O2 for shortness of breath but because saturation levels had not dropped it was determined O2 was not needed at that time. There was no evidence of COPD exacerbation. An addendum to the note, undated, indicated R1 had COPD and was O2 dependent. Saturation levels ran in the 85-90% range. The MD provided a recommendation for R1 to be on O2 around the clock (continuous) to maintain O2 levels at or above 90%.

A facility Progress Note dated 12/27/20, indicated R1's oxygen (O2) saturation was 60 - 70 % [average 90-100%] on room air. R1 had thick brown phlegm in his throat, he was coughing up and was placed on 2 liters of O2 with no improvement in O2 sats after four minutes. O2 was increased to 6 liters to maintain saturation levels of 89 - 91%. R1 coughed up large amounts of brown, sticky phlegm for about 45 minutes. Lung sounds were diminished but clear. After

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 5 coughing R1 was able to maintain O2 levels above 95% on 2 liters O2. R1's O2 Saturation Summary indicated on 12/29/20, R1 had a saturation level of 71% on room air at 7:00 a.m. No further O2 levels were documented until 10:00 p.m. when R1's O2 saturation level was 89% while O2. R1's Progress Note dated 12/30/20, indicated R1 was holding saliva in his mouth and would not swallow. The nurse attempted to suction R1 with no results. R1 had faint crackles in bases of lungs. A PT (physical therapy) Daily Treatment Note dated 12/30/20, indicated the therapist notified a nurse and nurse manager, about O2 saturation levels in the 70's on three liters of supplemental oxygen. The therapist increased R1's oxygen to 4-5 liters. R1's saturation levels only increased to 80%. R1's Progress Note dated 12/30/20, indicated R1 was seen by nurse practitioner (NP)-A by telehealth video. The facility nurse had reported abnormal lung sounds, deterioration of condition and requested orders for O2 and a wheel chair. A Documentation of Face to Face Encounter for Medicare Clients dated 12/30/20, written by NP-A indicated R1 was seen for a wheel chair and home oxygen. The note indicated R1 required as needed O2 to keep saturation levels above 88%. The encounter note indicated a diagnosis of emphysema; however, did not include an assessment of R1's lung condition. R1's Progress Note dated 12/30/20, identified R1 was resting in bed until being assisted into a wheel chair at 3:30 p.m. R1 was restless but	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 6	2 265		

weak, audible tracheal gurgling heard. R1 was encouraged to cough and deep breathe and able to clear. O2 was on at 2 liters. Resident was brought to the front entry. After R1 was brought to the entrance and was outside, writer returned to the unit.

R1's Discharge Summary dated 12/30/20, identified a health conditions of "COPD O2 sats [saturation] drop." However, the summary did not identify R1's current lung condition status.

An untitled hospital record dated 12/30/20, indicated upon arrival to the emergency room R1's blood pressure was 57/40 [average range 120/80 - 140/90]. The note indicated he was ill-appearing and looked toxic, vitals were not stable and he was unresponsive. The notes indicated R1 was in septic shock from presumed bacterial pneumonia and had severe, life threatening lactic acidosis (lactic acid is a substance that can build up in your body if you are not getting enough oxygen). The notes identified evidence or organ damage due to severe sepsis (infection in the blood) including acute respiratory failure, hypoxia (a decreased level of oxygen in all or part of your body) and hypercapnia (too much carbon dioxide in your bloodstream).

On 1/7/21, at 1:34 p.m. the assisted living facility (ALF) RN stated when R1 arrived at the ALF he was not very responsive. The ALF RN stated when she completed the admission assessment she reviewed the discharge documentation from the facility and it did not include an assessment or documentation of R1's condition when he left the facility so she had no baseline for him. The ALF RN stated R1's initial blood pressure was low, his heart rate was in the 40's [average range 60-100

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 7] and O2 saturation was in the high 80's. She stated later in the evening staff rechecked R1's vitals and his blood pressure was 50's/30's, O2 was in the 70's and staff were unable to detect a pulse on their equipment. R1 was then sent to the emergency room for further evaluation and passed away the next day. During interview on 1/7/21, at 3:39 p.m. NP-A stated she had seen R1 via video on 12/30/20, his condition had deteriorated since she last saw him on 12/7/20. NP-A reviewed R1's medical record and identified he was seen by NP-B on 12/23/20, and did not have an O2 order at that time. When asked about the face to face visit related to the O2 order on 12/30/20, NP-A stated the facility had called her on 12/30/20, and she was unable to complete the visit until later in the day so the facility called MD-A who then amended his note from the 12/22/20, visit. NP-A stated the order for the O2 was written by MD-A before she saw R1. Further, NP-A indicated she only saw R1 to fulfill a Medicare requirement for the face to face and did not identify she completed an actual assessment of R1's lung status. During interview on 1/8/21 at 8:57 a.m. registered nurse (RN)-A who was the unit nurse manager, stated, "I think his sats [saturation levels] dropped the Sunday before he discharged." RN-A stated MD-A and NP-A were both notified when R1 began to decline; however she had notified the medical providers only about R1's repeated falls. When asked about R1's overall decline, RN-A stated she did not think any medical interventions were implemented and stated RN-A stated she talked to MD-A and NP-A about the need for oxygen upon discharge from the facility, but stated she had not updated them regarding the saturation levels dropping into the 70% range and	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 8	2 265		

was not sure if any of the nurses had called and updated R1's medical providers. Further, the addendum on the physician's note dated 12/22/20, was added on 12/30/20, following her request for O2.

At 9:32 a.m. family member (FM)- A stated the facility had not contacted them and told them R1 needed O2. FM-A stated when R1 arrived at the assisted living facility his blood pressure was really, really low and he was sent to the emergency department. FM-A stated R1 was admitted to the intensive care unit and died from double pneumonia, organ failure and sepsis.

At approximately 10:00 a.m. physical therapist (PT)-A stated the day R1 discharged from the facility he had worked with R1 and R1's O2 saturation had dropped to 70% on two liters of O2. PT-A stated he reported it to the nurse on the floor who said RN-A was aware and they had been in contact with the physician. PT-A said the way it was communicated to him he thought it was something that was continually being monitored.

At 10:20 a.m. NP-B stated she had last seen R1 on 12/23/20, due to his multiple falls. NP-B stated she went on vacation and when she returned R1 had died. NP-B stated R1 had not required the use of O2 and his vitals signs had been stable. NP-B stated, "honestly, I don't believe anyone was notified of the change of condition" for R1.

At 11:29 a.m. MD-A stated on 12/30/20, he was trying to arrange for durable medical equipment for R1's discharge and had been speaking with RN-A. MD-A did not complete a face to face evaluation as MD-A stated he had not been aware of the decreased O2 saturation level.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 9 Further, if he was made aware of the change in R1's condition he would not have okayed him for discharge to the assisted living and would have sent R1 to the emergency department for further evaluation. On 1/11/21, at 10:48 a.m. the DON stated R1 had been declining throughout his stay at the facility however, she she would have expected staff to let the physician know of the decline in lung status and staff should have reported the saturation levels in the 70's. A facility policy related to notification of change of condition was requested but none received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies/procedures on notifying medical providers and family regarding significant changes in condition. The DON or designee could inservice nursing staff on ensuring the physician and family are notified timely of significant changes in resident condition, then audit charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out	2 830		2/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to assess and monitor a change in lung condition for 1 of 3 residents (R1) reviewed for a change of condition. This resulted in actual harm for R1 who was discharged to a lower level of care and subsequently transferred to the hospital the day of discharge, where R1 expired. Findings include: R1's undated, Admission Record indicated R1 admitted to the facility with diagnoses that included emphysema and chronic obstructive pulmonary disease (COPD). R1's admission Minimum Data Set (MDS) dated 11/24/20, indicated he had moderate cognitive impairment and required extensive assistance from two staff for activities of daily living. The MDS indicated R1 had not received oxygen therapy prior to or since admission to the facility. R1's care plan dated 11/27/20, identified a self performance deficit related to weakness, impaired mobility and deconditioning. The care plan directed staff to provide assistance of one staff to complete bathing, toileting and personal hygiene needs. The care plan lacked nursing interventions related to assessment or monitoring R1's COPD.	2 830	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11 R1's Oxygen (O2) Saturation Summary dated 11/18/20 - 12/30/20, indicated R1 did not use supplemental O2 from 11/18/20 to 12/27/20. The summary indicated on 12/27/20, R1's saturation levels were maintained at 89 - 98 % on room air [average range 90%-100%], without the need for supplemental O2. A physician Nursing Home Note dated 12/22/20, indicated R1 was seen via video visit by medical doctor (MD)-A. The note indicated at times R1 complained of dizziness and shortness of breath believed to be related to chronic atrial fibrillation. The note further identified a diagnosis of COPD and indicated R1 had no "clear cut" exacerbations, O2 readings have remained in a good range." Staff asked about potential for use of O2 for shortness of breath but because saturation levels had not dropped it was determined O2 was not needed at that time. There was no evidence of COPD exacerbation. An addendum to the note, undated, indicated R1 had COPD and was O2 dependent. Saturation levels ran in the 85-90% range. The MD provided a recommendation for R1 to be on O2 around the clock (continuous) to maintain O2 levels at or above 90%. A facility Progress Note dated 12/27/20, indicated R1's oxygen (O2) saturation was 60 - 70% on room air. R1 had thick brown phlegm in his throat, he was coughing up and was placed on 2 liters of O2 with no improvement in O2 sats after four minutes. O2 was increased to 6 liters to maintain saturation levels of 89 - 91%. R1 coughed up large amounts of brown, sticky phlegm for about 45 minutes. Lung sounds were diminished but clear. After coughing R1 was able to maintain O2 levels above 95% on 2 liters O2.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 12 The medical record lacked further assessment of R1's symptoms. R1's O2 Saturation Summary indicated on 12/29/20, R1 had a saturation level of 71% on room air at 7:00 a.m. No further O2 levels were documented until 10:00 p.m. when R1's O2 saturation level was 89% while O2. The medical record lacked evidence of ongoing monitoring or further assessment. R1's Progress Note dated 12/30/20, indicated R1 was holding saliva in his mouth and would not swallow. The nurse attempted to suction R1 with no results. R1 had faint crackles in bases of lungs. No further assessment was identified. A PT (physical therapy) Daily Treatment Note dated 12/30/20, indicated the therapist notified a nurse and nurse manager about R1 having O2 saturation levels in the 70's on three liters of supplemental oxygen during therapy. The therapist had increased R1's oxygen to 4-5 liters. R1's saturation levels only increased to 80%. R1's Progress Note dated 12/30/20, indicated R1 was seen by nurse practitioner (NP)-A by telehealth video. The note indicated the facility nurse reported abnormal lung sounds, deterioration of condition and requested orders for O2 and a wheel chair. The note was written by registered nurse (RN)-A. R1's Progress Note dated 12/30/20, indicated R1 was resting in bed until being assisted into a wheel chair at 3:30 p.m. R1 was restless but weak, audible tracheal gurgling was heard. R1 was encouraged to cough and deep breathe and able to clear. O2 was on at 2 liters. R1 was brought to the front entry and outside at which	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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

point the writer returned to the unit. The medical record again lacked evidence of further assessment or physician notification prior to discharging R1 from the facility.

R1's Discharge Summary dated 12/30/20, identified a health conditions of "COPD O2 sats [saturation] drop." However, the summary did not identify R1's current lung condition status or any further assessment of R1's lung condition.

An untitled hospital record dated 12/30/20, indicated upon arrival to the emergency room R1's blood pressure was 57/40 [average range 120/80 - 140/90]. The note indicated he was ill-appearing and looked toxic, vitals were not stable and he was unresponsive. The notes indicated R1 was in septic shock from presumed bacterial pneumonia and had severe, life threatening lactic acidosis (lactic acid is a substance that can build up in your body if you are not getting enough oxygen). The notes identified evidence or organ damage due to severe sepsis (infection in the blood) including acute respiratory failure, hypoxia (a decreased level of oxygen in all or part of your body) and hypercapnia (too much carbon dioxide in your bloodstream).

On 1/7/21, at 1:34 p.m. the assisted living facility (ALF) RN stated when R1 arrived at the ALF he was not very responsive. The ALF RN stated when she completed the admission assessment she reviewed the discharge documentation from the facility and it did not include an assessment or documentation of R1's condition when he left the facility so she had no baseline for him. The ALF RN stated R1's initial blood pressure was low, his heart rate was in the 40's [average range 60-100] and O2 saturation was in the high 80's. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 14	2 830		

stated later in the evening staff rechecked R1's vitals and his blood pressure was 50's /30's, O2 was in the 70's and staff were unable to detect a pulse on their equipment. R1 was then sent to the emergency room for further evaluation and passed away the next day.

During interview on 1/7/21, at 3:39 p.m. NP-A stated she had seen R1 via video on 12/30/20, his condition had deteriorated since she last saw him on 12/7/20. NP-A reviewed R1's medical record and identified he was seen by NP-B on 12/23/20, and did not have an O2 order at that time. When asked about the face to face visit related to the O2 order on 12/30/20, NP-A stated the facility had called her on 12/30/20, and she was unable to complete the visit until later in the day so the facility called MD-A who then amended his note from the 12/22/20, visit. NP-A stated the order for the O2 was written by MD-A before she saw R1. Further, NP-A indicated she only saw R1 to fulfill a Medicare requirement for the face to face and did not identify she completed an actual assessment of R1's lung status.

During interview on 1/8/21, at 8:26 a.m. nursing assistant (NA)-A stated R1 did not always use oxygen and stated the O2 use had started only a few days before he discharged.

At 8:57 a.m. RN-A, the unit manager, stated R1 had not used oxygen when he came to the unit and stated, "I think his sats [saturation levels] dropped the Sunday before he discharged." RN-A stated she talked to MD-A and NP-A about the need for oxygen upon discharge from the facility, but stated she had not updated them regarding the saturation levels dropping into the 70 % range and was not sure if any of the nurses had called and updated R1's medical providers. RN-A did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 15	2 830		

not identify why she did not discuss R1's dropping O2 saturations with MD-A. Further, the addendum on the physician's note dated 12/22/20, was added on 12/30/20, following her request for O2.

At 9:32 a.m. family member (FM)- A stated the facility had not contacted them and told them R1 needed O2. FM-A stated when R1 arrived at the assisted living facility his blood pressure was really, really low and he was sent to the emergency department. FM-A stated R1 was admitted to the intensive care unit and died from double pneumonia, organ failure and sepsis.

At approximately 10:00 a.m. physical therapist (PT)-A stated the day R1 discharged from the facility he had worked with R1 and R1's O2 saturation had dropped to 70% on two liters of O2. PT-A stated he reported it to the nurse on the floor who said RN-A was aware and they had been in contact with the physician. PT-A said the way it was communicated to him he thought it was something that was continually being monitored.

At 10:20 a.m. NP-B stated she had last seen R1 on 12/23/20, due to his multiple falls and was not related to R1's lung status. NP-B stated she went on vacation and when she returned R1 had died. NP-B stated at the time of her last visit R1 had not required the use of O2 and his vitals signs had been stable. NP-B stated, "honestly, I don't believe anyone was notified of the change of condition" for R1's lung status.

At 11:29 a.m. MD-A stated on 12/30/20, he was trying to arrange for durable medical equipment for R1's discharge and had been speaking with RN-A. MD-A did not complete a face to face

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 16	2 830		

evaluation as MD-A stated he had not been aware of the decreased O2 saturation level. Further, if he was made aware in the change in R1's lung condition he would not have okayed him for discharge to assisted living and would have sent R1 to the emergency department for further evaluation.

On 1/11/21, at 10:48 a.m. the director of nursing (DON) stated R1 had been declining throughout his stay at the facility. The DON stated over the weekend prior to his discharge he was requiring O2 when he couldn't clear his mucous but it was "periodic." The DON stated R1 did not display a drastic change in his vital signs and his O2 saturations levels were not real low. She stated she felt it was "just a slow decline." The DON stated she was aware the day of discharge they were evaluating R1's need for O2 and said the reports she received was R1 was doing what he had been doing for weeks and was regularly using O2. The DON stated "It was a slow and consistent decline in my opinion," but stated she would have expected staff to report the saturation levels in the 70's and to let the physician know of the decline.

The facility policy Change In Condition Evaluation - CICE dated 12/11/20, directed staff to begin the CICE and collect pertinent clinical data prior to contacting the physician when a resident experienced a change of condition and continue to monitor the resident and update the CICE evaluation as appropriate. Upon completion of the evaluation, a notification hyperlink will turn red if there is information that needs to be communicated to the provider.

R1's medical record lacked a CICE form related to a change in condition in lung status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 17 SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services when experiencing a change of condition. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		