Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 25, 2024

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

RE: CCN: 245500
Cycle Start Date: June 12, 2024

Dear Administrator:

On June 12, 2024, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 12, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 12, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 06/12/2024

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

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F 000	INITIAL COMMENTS On 6/11/24 through 6/12/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55004405C (MN00103928) with a deficiency issued at F689, H55004409C (MN00098555), with a deficiency issued at F686, H55004410C (MN00101324). As a result of the investigation, an additional deficiency was cited at F660. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix)	F 660		7/25/24

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

Electronically Signed | 07/02/2024

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

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F 660	Continued From page 1 §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 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	F 660		

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F 660	Continued From page 2 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 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 create an individualized discharge care plan, to develop interventions to meet the resident's discharge goals and needs to ensure a	F 660	F660 SS=D 1) Social services immediately audited all care plans and made sure discharge plans and discharge goals were explicitly	

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F 660	Continued From page 3 smooth and safe transition from the facility to the post-discharge setting, for 1 of 3 residents (R3) reviewed. Findings include: R3's quarterly Minimal Data Set (MDS) dated 2/19/24, indicated R3 had diagnoses of heart failure, respiratory failure, and was cognitively intact. Further, assessment indicated there was an active discharge plan in place for R3 to return to the community and a referral had been made to the Local Contact Agency. R3's care plan dated 3/28/24, lacked evidence of a comprehensive discharge plan to address the goals for care, treatment preferences, identify needs that must be addressed before discharge, interest in and any referrals made to the local contact agency, as well as identifying post-discharge needs such as nursing, therapy services, medical equipment or modifications to the home, or activities of daily living (ADLs) assistance. On 6/12/24 at 1:25 p.m., social services (SS)-A stated discharge planning started the day the resident was admitted to the facility and the planning continues to be in progress during the resident's stay at that facility. Further, SS-A stated she does not add discharge planning into the resident's care plan but keeps the information "in my brain". On 6/12/24 at 4:27 p.m., attempt to interview registered nurse (RN)-E was unsuccessful. On 6/12/24 at 4:38 p.m., director of nursing (DON) stated SS would be expected to develop a	F 660	stated. 2) All residents are at risk of not having a discharge plan with goals in their care plan. 3) Social services staff were reeducated by DNS as to the requirement that all residents have a discharge plan and discharge goals set up when they first admit to the facility. This has been specifically and clearly pointed out as a part of the social services' workflow. Social workers will be responsible for reporting every new entry to the facility and their discharge plan and goal status to auditors until such a time that the QAPI committee feels that they are following the process correctly and proficiently. 4) DNS or designee will audit all new admissions each week for 6 weeks to ensure that they have discharge plans and discharge goals are included in the care plan. They will submit the findings of these audits to the QAPI committee for review and further instructions. 5) To be corrected by July 25th 2024	

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F 660	Continued From page 4 comprehensive discharge plan in the resident's care plan that would include the resident's wishes, desires, plan, and goals. DON confirmed R3 did not have a discharge plan in her care plan. On 6/12/24 at approximately 4:38 p.m., a policy related to discharge planning was requested, but facility failed to provide a copy.	F 660		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure physician treatment orders were followed for 1 of 3 (R2) residents reviewed for pressure ulcers. Findings include: R2's quarterly Minimal Data Set (MDS) dated 5/14/24, indicated R2 had diagnoses of pressure ulcer of left buttock, pressure ulcer of the sacral region and was cognitively intact.	F 686	F686 SS=D 1) Wound dressing was immediately corrected on affected resident. DNS immediately reeducated the nurse on how to properly follow physician's orders for treatments. 2) All residents with wounds are at risk if their physician's orders to treat their wounds are not followed.	7/25/24

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F 686	Continued From page 5 R2's Wound Data Collection dated 6/6/24, indicated the wound was in the peri-anal area which originally started as a moisture associate skin injury. The wound measure 5 centimeters (cm) long by 5 cm width and depth carried due to tunneling at 3:00 measuring 3 cm and tunneling between 12:00 and 1:00 measured 9.5 cm. Per wound care nurse at the hospital there was necrotic tissue on the distal area of the wound. R2's Order Summary Report dated 6/6/24, indicated wound care instructions for R2's sacral wound included: cleanse wound with saline and pat dry, wet-dry dressing changes utilizing sterile saline, ensure tail for easy removal, and apply ABD and secure with Medipore tape. On 6/12/24 at 10:44 a.m., registered nurse (RN)-A knocks and enters R2's room to completed R2's wound care. RN-A was observed to wash her hands in the bathroom, she then applied an isolation gown and gloves. RN-A stated she removed the old dressing from the wound on R1's bottom placed into the garbage can along with her soiled gloves. RN-A washed hands in the bathroom and applied clean gloves. RN-A then cleaned the wound with saline and gauze pad and RN-A stated the wound looked like it had improved with no signs of infection, no necrotic tissue noted, and no odor. RN-A removed soiled gloves into the garbage can and washed hands in the bathroom and applied clean gloves. RN-A soaks gauze with sterile saline and packs the gauze into the wound using a sterile cotton swab and left a tail of gauze out. RN-A removes gloves into the garbage and washed hands in the bathroom and applied clean gloves. RN-A soaks cotton swab with sterile saline and	F 686	3) All nurses will have competencies for wound care reverified in addition to receiving education on how to follow physician's orders for treatments. They were also given guidelines to help follow this system created by the DNS. The facility will audit to ensure that the new system are being followed by auditing until staff display proficiency and correct process for following the new system. 4) The DNS or designees will audit the changing of all wounds in the building weekly for 6 weeks to ensure that physician's orders are being followed. They will then submit the findings of these audits to the QAPI committee for review and further instructions. 5) To be corrected by July 25th 2024	

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F 686	Continued From page 6 cleans around the wound on the tissue. RN-A again removed soiled gloves and washes hands in the bathroom. RN-A stated R1's wound care was complete and assisted the nursing assistant with getting R1's incontinent brief back on. Further, when questioned about R2's treatment order RN-A went to R2's wound supply drawer and stated staff do not cover the wound or use tape, leave as is with the gauze. At 11:03 a.m., RN-A entered RN-D's office and questioned about the pad and tape over the gauze. On 6/12/24 at 11:03 a.m., RN-D confirmed R2's wound needed to be covered with an ABD pad (abdominal pad used as a secondary dressing over wounds that discharge fluid). RN-D knocks on R2's door and explained RN-D needed to cover the wound, which R2 was compliant. RN-D applied gown and gloves and places the ABD pad over the wound and applied tape to both sides. RN-D stated the wound was open and we are trying to protect it. RN-D stated the wound had improved. On 6/12/24 at 11:16 a.m. RN-A stated she typically did not work on R2's unit but staff were expected to review the resident's treatment administration record (TAR) for the wound treatment order. RN-A confirmed at the start of R2's wound treatment when she removed the old gauze from R2's wound, the wound was not covered with an ABD pad or taped. Further, RN-A stated R2 could have removed the tape himself and RN-A did not recall any concerns regarding R2's wound or him removing the dressing through report from previous shift. On 6/12/24 at 11:28 a.m., R2 denied removing any dressing from his wound, and did not remove	F 686		

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F 686	Continued From page 7 any gauze or tape. R2 confirmed the previous nurse did not cover or put tape on the wound from the previous day. On 6/12/24 at 4:38 p.m., director of nursing (DON) indicated staff were expected to read each resident's wound treatment order each time they do the treatment. DON stated if the order was complex the staff could write the order on a piece of paper to bring with them while they complete the treatment or if there were multiple steps to the treatment order the nurse could print the order as well. On 6/12/24 at approximately 4:38 p.m., a pressure wound policy and treatment order policy was requested, however facility failed to provide a copy.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide adequate supervision for 1 of 3 residents (R1) reviewed, who was cognitively impaired and arrived at an outpatient appointment unaccompanied and was noted to be disorientated and exhibiting aggressive behaviors.	F 689	F 689 SS=D 1) The DNS and designees immediately reviewed all appointments in the next 2 weeks to ensure there was a plan for accompaniment of residents who need supervision. A plan was made for	7/25/24

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F 689	Continued From page 8 Findings include: R1's quarterly Minimal Data Set dated 6/4/24, indicated R1 had a diagnosis of Alzheimer's Disease and had severely impaired cognition. Further, R1's MDS revealed R1 exhibited physical and verbal behavioral symptoms. R1's care plan as of 6/11/24, indicated R1 had impaired cognition or impaired though process related to Alzheimer's disease and was exhibited by forgetfulness, confusion and often refusals of care. R1 required assistance by staff for all activities of daily living (ADLs) which included bed mobility, dressing, toileting, and transfers. Further, R1's care plan revealed R1 would exhibit behaviors of resistive to cares and screaming at others and directed staff to provide consistency in care and maintain consistency in timing of ALDs, caregivers, and routine. R1's progress note dated 6/5/24, indicated a nurse from the orthopedics clinic called the facility and stated R1 was not orientated to person and could not verify was he was. After the facility verified R1's identity, R1's vitals were obtained, and his blood pressure was noted to be 80/50 and had a temperature of 99.5. Orthopedic nurse stated R1 was being transferred to the emergency department for further assessment. On 6/12/24 at 8:40 a.m., R1 was observed sitting in his wheelchair in his room. R1 could not recall going to an orthopedic appointment at the clinic independently. On 6/12/24 at 11:16 a.m., registered nurse (RN)-A stated R1 had impaired cognition	F 689	reviewing appointments going forward to determine and plan for supervision as needed for residents at risk. 2) All residents who need supervision for safety are at risk when at an appointment without a supervisor. 3) A new system was put into place by DNS and the Director of Health Information Management to determine based on RN and/or social workers assessment and designate which residents need accompaniment when at appointments, and to ensure that those residents are then accompanied to appointments. All residents will have a statement in their chart on whether or not they can attend appointments alone. Education was done for all staff to ensure that they are aware of this process. This item will be audited to ensure that the new system is working. 4) The Director of Health Information Management or designee will audit all appointments at the end of each week to ensure that all residents in need of supervision at appointments did in fact have supervision at their appointment. They will do this for 6 weeks. They will then submit the findings of these audits to the QAPI committee for review and further instructions. 5) To be corrected by July 25th 2024	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9 exhibited by confusion and would "get ornery" and would swing, grab, and hit at staff. RN-A stated R1 would not be able to make his own medical decisions and his daughters would go with to all appointments. Further, RN-A stated if a resident had impaired cognition, confused, and were not able to be accompanied by either a relative or friend to an appointment the resident would not go to the appointment and facility would find alternative ways such as if the outpatient service could be provided at the facility. On 6/12/24 at 11:33 a.m., nursing assistant (NA)-A stated R1 was confused, couldn't understand staff, and have a fluent conversation with staff as his answers would not be appropriate to questions. NA-A stated due to R1's cognition and behaviors such as hitting and kicking, R1 would not be safe to independently go out into the community by himself. On 6/12/24 at 11:51 a.m. family member (FM)-A stated R1's had a scheduled orthopedic appointment for an injection to R1's knee and the nurse from the clinic called FM-A and reported R1 was confused and could not recall his last name, date of birth, or the reason for his appointment. FM-A stated the facility staff were aware family would not be there as FM-A was not in the state and FM-A was told staff were not able to attend the appointment with R1, but FM-A was unsure why. FM-A confirmed R1 had went to the appointment unaccompanied and without an advocate there for him. On 6/12/24 at 1:06 p.m., RN-B stated R1 was frequently confused, and short-term memory and safety awareness were impaired. RN-B stated R1 had two daughters who were Power of Attorney	F 689		

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	245500	A. BUILDING _____ B. WING _____	C 06/12/2024

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F 689	Continued From page 10 and would assist in any medical decisions. Further, RN-B stated R1 would not be safe to be unaccompanied out in the community as he could injury himself or someone else if "something set him off" due to R1 exhibiting some physical aggression. RN-B confirmed on 6/5/24, R1 had an appointment and was being transported by Medi-van (transportation service company) unaccompanied. RN-B stated as a floor nurse they assist with getting the resident ready for the appointment and get any paperwork ready that may be needed, but the floor nurse would not have been the one to schedule the appointment, transportation, or contacting a family or friend to assist the resident with the appointment as that would be role of the health information staff. On 6/12/24 at 1:22 p.m., health information (HI)-A stated she would schedule all appointments for the residents on the unit R1 was currently residing on. HI-A stated she was not responsible for assessing and determining if a resident was safe and appropriate to attend an appointment unaccompanied. HI-A stated she would contact the first emergency contact listed for the resident and if a resident would go unaccompanied HI-A stated she would consult with the nurse manager on the unit especially if the resident exhibits behaviors. Further, HI-A stated R1 had an orthopedic appointment that was scheduled, and HI-A spoke with one of R1's daughters, unsure which one, in person and had asked if the daughter was accompanying R1 to the appointment which daughter stated she was not. HI-A did not consult with R1's nurse manager about the appointment. On 6/12/24 at 2:20 p.m., RN-C stated facility process for resident appointments was the HI	F 689		

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F 689	Continued From page 11 staff would notify family and ask if transportation would need to be arranged and give the resident a green slip of paper that would have detailed information regarding the appointment including time, where, and what they will have done. RN-C stated if the resident was cognitively impaired, and family was unable to accompany the resident to the appointment the facility would attempt to arrange the appointment for when family would be available to accompany the resident or if the clinic was familiar with the resident and their doctor was aware of the resident then the resident would be able to go to the appointment unaccompanied. Further, RN-C stated R1 had some confusion, safety awareness was "non-existent", and R1 had exhibited physically aggressive behaviors towards staff. RN-C stated FM-A made an orthopedic appointment for R1 and had asked the facility to set up transportation for R1. RN-C stated the facility was not aware family was not accompanying R1 to the appointment and RN-C had not contacted the clinic to inform them about R1's behaviors. In addition, RN-C stated R1 will no longer be able to go to appointment unaccompanied as the facility "learned from the mistakes". On 6/12/24, at 4:15 p.m., director of nursing (DON) stated if a resident could advocate and was alert and orientated, they would be able to go to an appointment unaccompanied, however, if the resident was not then they would require to be accompanied by family or friend. If a family or friend was unable to accompany a cognitively impaired resident, then the facility would attempt to arrange services for in house at the facility. DON stated R1 had impaired cognition and had a diagnosis of dementia, and R1's behaviors had been challenging and violent at times. Further,	F 689		

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F 689	Continued From page 12 DON stated she was aware R1 had went to an orthopedic appointment unaccompanied by family but was not aware until the nurse from the clinic called the facility to speak with the nurse on his unit. DON stated if HI staff were aware family was not accompanying R1 then the appointment should have been canceled or in urgent situations DON stated she would accompany a resident. In addition, DON stated she had not investigated the incident and has not discussed where the facility's process had failed with HI staff or R1's nurse manager. On 6/12/24, at approximately 4:15 p.m., policy regarding appointments and/or supervision was requested but not provided.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 25, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 07MM11

Dear Administrator:

The above facility was surveyed on June 11, 2024 through June 12, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 06/12/2024

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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 6/11/24 through 6/12/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H55004405C (MN00103928) with a licensing order issued at 0830, H55004409C (MN00098555), with a licensing order issued at 0900, H55004410C (MN00101324). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	2 000		

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2 000	Continued From page 2 is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide adequate supervision for	2 830	Corrected	7/25/24

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2 830	Continued From page 3 1 of 3 residents (R1) reviewed, who was cognitively impaired and arrived at an outpatient appointment unaccompanied and was noted to be disorientated and exhibiting aggressive behaviors. Findings include: R1's quarterly Minimal Data Set dated 6/4/24, indicated R1 had a diagnosis of Alzheimer's Disease and had severely impaired cognition. Further, R1's MDS revealed R1 exhibited physical and verbal behavioral symptoms. R1's care plan as of 6/11/24, indicated R1 had impaired cognition or impaired though process related to Alzheimer's disease and was exhibited by forgetfulness, confusion and often refusals of care. R1 required assistance by staff for all activities of daily living (ADLs) which included bed mobility, dressing, toileting, and transfers. Further, R1's care plan revealed R1 would exhibit behaviors of resistive to cares and screaming at others and directed staff to provide consistency in care and maintain consistency in timing of ALDs, caregivers, and routine. R1's progress note dated 6/5/24, indicated a nurse from the orthopedics clinic called the facility and stated R1 was not orientated to person and could not verify was he was. After the facility verified R1's identity, R1's vitals were obtained, and his blood pressure was noted to be 80/50 and had a temperature of 99.5. Orthopedic nurse stated R1 was being transferred to the emergency department for further assessment. On 6/12/24 at 8:40 a.m., R1 was observed sitting in his wheelchair in his room. R1 could not recall going to an orthopedic appointment at the clinic	2 830		

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2 830	Continued From page 4 independently. On 6/12/24 at 11:16 a.m., registered nurse (RN)-A stated R1 had impaired cognition exhibited by confusion and would "get ornery" and would swing, grab, and hit at staff. RN-A stated R1 would not be able to make his own medical decisions and his daughters would go with to all appointments. Further, RN-A stated if a resident had impaired cognition, confused, and were not able to be accompanied by either a relative or friend to an appointment the resident would not go to the appointment and facility would find alternative ways such as if the outpatient service could be provided at the facility. On 6/12/24 at 11:33 a.m., nursing assistant (NA)-A stated R1 was confused, couldn't understand staff, and have a fluent conversation with staff as his answers would not be appropriate to questions. NA-A stated due to R1's cognition and behaviors such as hitting and kicking, R1 would not be safe to independently go out into the community by himself. On 6/12/24 at 11:51 a.m. family member (FM)-A stated R1's had a scheduled orthopedic appointment for an injection to R1's knee and the nurse from the clinic called FM-A and reported R1 was confused and could not recall his last name, date of birth, or the reason for his appointment. FM-A stated the facility staff were aware family would not be there as FM-A was not in the state and FM-A was told staff were not able to attend the appointment with R1, but FM-A was unsure why. FM-A confirmed R1 had went to the appointment unaccompanied and without an advocate there for him. On 6/12/24 at 1:06 p.m., RN-B stated R1 was	2 830		

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2 830	Continued From page 5 frequently confused, and short-term memory and safety awareness were impaired. RN-B stated R1 had two daughters who were Power of Attorney and would assist in any medical decisions. Further, RN-B stated R1 would not be safe to be unaccompanied out in the community as he could injury himself or someone else if "something set him off" due to R1 exhibiting some physical aggression. RN-B confirmed on 6/5/24, R1 had an appointment and was being transported by Medi-van (transportation service company) unaccompanied. RN-B stated as a floor nurse they assist with getting the resident ready for the appointment and get any paperwork ready that may be needed, but the floor nurse would not have been the one to schedule the appointment, transportation, or contacting a family or friend to assist the resident with the appointment as that would be role of the health information staff. On 6/12/24 at 1:22 p.m., health information (HI)-A stated she would schedule all appointments for the residents on the unit R1 was currently residing on. HI-A stated she was not responsible for assessing and determining if a resident was safe and appropriate to attend an appointment unaccompanied. HI-A stated she would contact the first emergency contact listed for the resident and if a resident would go unaccompanied HI-A stated she would consult with the nurse manager on the unit especially if the resident exhibits behaviors. Further, HI-A stated R1 had an orthopedic appointment that was scheduled, and HI-A spoke with one of R1's daughters, unsure which one, in person and had asked if the daughter was accompanying R1 to the appointment which daughter stated she was not. HI-A did not consult with R1's nurse manager about the appointment.	2 830		

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2 830	Continued From page 6 On 6/12/24 at 2:20 p.m., RN-C stated facility process for resident appointments was the HI staff would notify family and ask if transportation would need to be arranged and give the resident a green slip of paper that would have detailed information regarding the appointment including time, where, and what they will have done. RN-C stated if the resident was cognitively impaired, and family was unable to accompany the resident to the appointment the facility would attempt to arrange the appointment for when family would be available to accompany the resident or if the clinic was familiar with the resident and their doctor was aware of the resident then the resident would be able to go to the appointment unaccompanied. Further, RN-C stated R1 had some confusion, safety awareness was "non-existent", and R1 had exhibited physically aggressive behaviors towards staff. RN-C stated FM-A made an orthopedic appointment for R1 and had asked the facility to set up transportation for R1. RN-C stated the facility was not aware family was not accompanying R1 to the appointment and RN-C had not contacted the clinic to inform them about R1's behaviors. In addition, RN-C stated R1 will no longer be able to go to appointment unaccompanied as the facility "learned from the mistakes". On 6/12/24, at 4:15 p.m., director of nursing (DON) stated if a resident could advocate and was alert and orientated, they would be able to go to an appointment unaccompanied, however, if the resident was not then they would require to be accompanied by family or friend. If a family or friend was unable to accompany a cognitively impaired resident, then the facility would attempt to arrange services for in house at the facility. DON stated R1 had impaired cognition and had a diagnosis of dementia, and R1's behaviors had	2 830		

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2 830	Continued From page 7 been challenging and violent at times. Further, DON stated she was aware R1 had went to an orthopedic appointment unaccompanied by family but was not aware until the nurse from the clinic called the facility to speak with the nurse on his unit. DON stated if HI staff were aware family was not accompanying R1 then the appointment should have been canceled or in urgent situations DON stated she would accompany a resident. In addition, DON stated she had not investigated the incident and has not discussed where the facility's process had failed with HI staff or R1's nurse manager. On 6/12/24, at approximately 4:15 p.m., policy regarding appointments and/or supervision was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to appropriate supervision related to outpatient appointments for cognitively impaired residents. The DON or designee could also and ensure appropriate comprehensive assessments and interventions were developed and implemented for all residents with the potential to be affected. The DON or designee could re-educate all staff on policies and procedures, changes to care plans, and the results of assessments for those identified at risk. The DON or designee could audit outpatient appointments to ensure appropraite supervision was provided to each resident. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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	00087	A. BUILDING: _____ B. WING _____	C 06/12/2024

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
2 900	Continued From page 8	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure physician treatment orders were followed for 1 of 3 (R2) residents reviewed for pressure ulcers. Findings include: R2's quarterly Minimal Data Set (MDS) dated 5/14/24, indicated R2 had diagnoses of pressure ulcer of left buttock, pressure ulcer of the sacral region and was cognitively intact. R2's Wound Data Collection dated 6/6/24, indicated the wound was in the peri-anal area which originally started as a moisture associate skin injury. The wound measure 5 centimeters (cm) long by 5 cm width and depth carried due to	2 900	Corrected	7/25/24

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2 900	Continued From page 9 tunneling at 3:00 measuring 3 cm and tunneling between 12:00 and 1:00 measured 9.5 cm. Per wound care nurse at the hospital there was necrotic tissue on the distal area of the wound. R2's Order Summary Report dated 6/6/24, indicated wound care instructions for R2's sacral wound included: cleanse wound with saline and pat dry, wet-dry dressing changes utilizing sterile saline, ensure tail for easy removal, and apply ABD and secure with Medipore tape. On 6/12/24 at 10:44 a.m., registered nurse (RN)-A knocks and enters R2's room to completed R2's wound care. RN-A was observed to wash her hands in the bathroom, she then applied an isolation gown and gloves. RN-A stated she removed the old dressing from the wound on R1's bottom placed into the garbage can along with her soiled gloves. RN-A washed hands in the bathroom and applied clean gloves. RN-A then cleaned the wound with saline and gauze pad and RN-A stated the wound looked like it had improved with no signs of infection, no necrotic tissue noted, and no odor. RN-A removed soiled gloves into the garbage can and washed hands in the bathroom and applied clean gloves. RN-A soaks gauze with sterile saline and packs the gauze into the wound using a sterile cotton swab and left a tail of gauze out. RN-A removes gloves into the garbage and washed hands in the bathroom and applied clean gloves. RN-A soaks cotton swab with sterile saline and cleans around the wound on the tissue. RN-A again removed soiled gloves and washes hands in the bathroom. RN-A stated R1's wound care was complete and assisted the nursing assistant with getting R1's incontinent brief back on. Further, when questioned about R2's treatment order RN-A went to R2's wound supply drawer	2 900		

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2 900	Continued From page 10 and stated staff do not cover the wound or use tape, leave as is with the gauze. At 11:03 a.m., RN-A entered RN-D's office and questioned about the pad and tape over the gauze. On 6/12/24 at 11:03 a.m., RN-D confirmed R2's wound needed to be covered with an ABD pad (abdominal pad used as a secondary dressing over wounds that discharge fluid). RN-D knocks on R2's door and explained RN-D needed to cover the wound, which R2 was compliant. RN-D applied gown and gloves and places the ABD pad over the wound and applied tape to both sides. RN-D stated the wound was open and we are trying to protect it. RN-D stated the wound had improved. On 6/12/24 at 11:16 a.m. RN-A stated she typically did not work on R2's unit but staff were expected to review the resident's treatment administration record (TAR) for the wound treatment order. RN-A confirmed at the start of R2's wound treatment when she removed the old gauze from R2's wound, the wound was not covered with an ABD pad or taped. Further, RN-A stated R2 could have removed the tape himself and RN-A did not recall any concerns regarding R2's wound or him removing the dressing through report from previous shift. On 6/12/24 at 11:28 a.m., R2 denied removing any dressing from his wound, and did not remove any gauze or tape. R2 confirmed the previous nurse did not cover or put tape on the wound from the previous day. On 6/12/24 at 4:38 p.m., director of nursing (DON) indicated staff were expected to read each resident's wound treatment order each time they do the treatment. DON stated if the order was	2 900		

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2 900	Continued From page 11 complex the staff could write the order on a piece of paper to bring with them while they complete the treatment or if there were multiple steps to the treatment order the nurse could print the order as well. On 6/12/24 at approximately 4:38 p.m., a pressure wound policy and treatment order policy was requested, however facility failed to provide a copy. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		