Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 5, 2025

Administrator
Good Samaritan Society - Blackduck

172 SUMMIT AVENUE WEST
BLACKDUCK, MN 56630

RE: CCN:245600
Cycle Start Date: December 12, 2025

Dear Administrator:

On December 5, 2025, 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
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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 March 5, 2026(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 June 5, 2026(six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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December 5, 2025

Administrator
Good Samaritan Society - Blackduck
172 SUMMIT AVENUE WEST
BLACKDUCK, MN 56630

Re: State Nursing Home Licensing Orders
Event ID: 1DA744-H1

Dear Administrator:

The above facility survey was completed on December 5, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Blackduck	**172 SUMMIT AVENUE WEST , BLACKDUCK, Minnesota, 56630**

(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
20000	Initial Comments	20000		12/15/2025

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 10/30/25 through 10/31/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure.

The following complaint was reviewed during the survey. H56006603C 2653693 with a licensing order issued at 0830.

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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20000	Continued from page 1 Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to perform ongoing and accurate assessment of pressure ulcers for 2 of 3 residents (R1,R3) who were at risk for pressure ulcer development. In addition, the facility failed to implement interventions to reduce the risk for new or worsening pressure ulcers. Findings include: R1's Admission Record indicated she admitted to the facility on 10/16/25. R1's diagnosis included dehydration, Parkinson's disease, anxiety and weakness. R1's Braden Scale for Predicting Pressure Sore Risk dated 10/16/25, indicated a score of 13, which indicated moderate risk. R1's Nursing Admit Re-Admit Data Collection dated 10/16/25 at 4:33 p.m., indicated skilled services to include wound care. Skin integrity assessment indicated a dehisced (partial or total separation of previously approximated wound edges, due to a failure of proper wound healing) scar on the left side of her abdomen, left buttock: crease area unstageable ulcer due to previous location and a scratch on her arm. R1's Wound Data Collection dated 10/16/25 at 5:15 p.m., identified an unstageable decubitus (a type of skin injury caused by prolonged pressure on the skin, which restricts blood flow and can lead to tissue damage and death) ulcer on the left buttock that measured 3 centimeters (cm) x .75 cm. Surrounding skin pink and intact. Wound bed 100% granulation tissue (described as	20830	Corrected	12/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2025

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20830	Continued from page 2 being red and moist, with a bumpy or granular appearance due to new capillary buds, fibroblasts, and collagen), which indicated a stage III pressure ulcer. Wound margins were intact and pink. R1's Wound Data Collection dated 10/16/25 at 5:24 a.m., identified a wound (no description) on the left iliac crest (the curved area on the sides of the hip bones of the pelvic girdle) that measured 3.5 cm x 1 cm x .75 cm. Drainage present on dressing, surrounding tissue intact and tunneling (a chronic wound with an opening that extends into a narrow passageway or channel beneath the skin's surface) present. Wound characteristic not completed. Drainage amount indicated moderate, color indicated purulent (white, yellow, green, brown, or sometimes pink-tinged). R1's Wound RN (registered nurse) Assessment dated 10/16/25 at 5:32 a.m., indicated an unstageable pressure ulcer to the left buttock, present on admission. The assessment indicated, continue with current plan of treatment. R1's Wound Data Collection dated 10/22/25 at 8:09 a.m., identified a stage I pressure ulcer (the earliest stage of a pressure injury, characterized by reddened, unbroken skin that does not turn white when pressed) to the left buttock that measured 3 cm x .35 cm. Wound characteristics indicated 100% granulation tissue. Surrounding tissue identified as macerated (softened, wrinkled tissue due to moisture) and reddened. RN to assess change in wound status. R1's Wound Data Collection dated 10/22/25 at 11:50 a.m., identified a wound on the coccyx (the final bone at the bottom of the spine) that measured 2.5 cm x 1 cm. Description was left blank. Wound characteristics indicated 100% granulation tissue. Surrounding tissue macerated and reddened. RN to assess change in wound status. R1's Wound RN assessment dated 10/23/25 at 3:40 p.m., identified a non-pressure related wound on the iliac crest. Tissue loss indicated full thickness loss (a severe wound that extends through all layers of the skin and into underlying structures like fat, muscle, tendon, or bone). Physician was notified regarding wound status, requesting wound consult. R1's Wound RN Assessment dated 10/23/25 at 3:42 a.m., identified an unstageable pressure ulcer on the left buttock. R1's care plan dated 10/16/25, identified a self-care	20830		

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20830	Continued from page 3 deficit related to weakness. The care plan directed staff to assist with bed mobility, transfers and toilet use. The care plan identified a potential and actual impairment to skin integrity and open wounds and an unstageable pressure ulcer on the left buttock. The care plan directed staff to monitor size, location and treatment of skin injury, provide pressure relieving device and or skin protective device (unspecified), on heels, elbows, etcetera (not specified). Frequency not specified. The care plan indicated avoid positioning on back. R1's care plan identified Parkinson's disease and indicated. monitor voiding pattern and continence and implement toileting program if needed. R1's Kardex (care guide) dated 10/31/25, lacked direction to staff related to mobility, transfers and frequency of repositioning or toileting. R1's discharge Minimum Data Set (MDS) dated 10/24/25, identified an unstageable deep tissue injury, present on admission. R1's Progress Notes identified the following: 10/17/25, Daily vitals, medication administration, dressing changes. Wound still open, no swelling or redness surrounding (wound location not identified). Transfer assist of two with mechanical lift. 10/19/25, R1 intermittently incontinent of large amounts of urine and required a full bed change over the past three overnight shifts. 10/20/25, Daily vitals, medication administration, dressing changes. Wound is still open, no swelling or redness (wound location not identified). 10/21/25, Daily vitals, medication administration, dressing changes. Wound is still open, no swelling or redness (wound location not identified). 10/22/25, R1 had a 10 cm diameter reddened coccyx and buttocks. 10/22/25, R1 did not want to get out of bed. staff did frequent position changes. 10/23/25, Small red area on sternum. 10/24/25, R1 discharged to the hospital due to altered mental status. During interview on 10/30/25, at 2:09 p.m., R1's significant other (SO) stated every time he visited R1	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2025

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20830	Continued from page 4 at the facility she had been incontinent of bowel and not cleaned up. He said R1 was lying in feces every time he visited and said the time varied. The SO said R1 was currently in the hospital and was "covered in sores." SO said when R1 admitted to the facility her sores had been healed up. The SO stated, "I couldn't believe it when she got to the hospital and saw all of the sores." During interview on 10/31/25 at 10:27 a.m., licensed practical nurse (LPN)-A said skin assessments were completed every week on bath day. LPN-A said if a skin concern was identified it was noted and if no skin check was noted there was a spot on the form to indicate the skin check had been completed. LPN-A said R1 had multiple skin concerns, one on her abdominal fold and her coccyx. LPN-A said those were the wounds that had daily dressings. LPN-A said the wound on R1's coccyx was about the size of a quarter, red with blood-tinged fluid and looked like shearing (type of skin injury caused by opposing forces pulling on the skin and underlying tissues, often resulting in damage to deeper layers of skin and tissue). The abdominal fold was red and open, kind of "oozy" with clear drainage and about the size of a dime. LPN-A said she remembered a wound on the left buttock but did not recall what it looked like. On 10/31/25 at 11:21 a.m., NA-A and NA-B were interviewed. NA-A said they used the Kardex to determine how the care for the residents. NA-A said they had assignment sheets also because things changed often. If a new admission, NA-A said they asked the nurse for the information. NA-B said R1 had a lot of loose stools so she was changed every two hours and cream was applied. NA-B said she got "pretty raw." NA-A said R1's coccyx was very red. NA-A said R1 always had a heated blanket on her chest and got a bigger sore that was red. During interview on 10/31/25 at 11:46 a.m., RN-A said she had not completed any of R1's wound assessments but had addressed the wound in progress notes. RN-A said R1 had two or three openings on the left side under her abdominal folds that had dressings placed on them. RN-A said R1 also had a wound on her coccyx, one on the gluteal cleft and one on her labia. RN-A said she had seen the wounds the day before R1 went to the hospital. RN-A said the labia wound looked like a scratch and said R1 had lines in her skin like her incontinent brief had been too tight. The gluteal cleft was described as a stage I, the top layer of skin was	20830		

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20830	Continued from page 5 missing. RN-A described the coccyx wound as an opening with the top layer of skin missing. RN-A said R1's sternum was very prominent and said it looked her gown was always rubbing on it. She said R1 had a wound about the size of the tip of a pinky finger on her chest. R3's Admission Record indicated he admitted to the facility 9/14/21. Diagnosis included dementia, heart disease, pain and history of falls. R3's care plan dated 6/5/25, identified limited physical mobility, and a self-care deficit and incontinence related to deconditioning. The care plan indicated R3 required the use of a mechanical lift for transfers and required assistance from staff for bed mobility and toileting. The care plan directed staff to check every two to three hours for incontinence. The care plan further identified an alteration in skin integrity related to reduced physical mobility and directed staff to assist to turn and reposition frequently during the day and at 12:00 a.m. and 4:00 a.m., use of a pressure reducing mattress and protective boots at night. R3's Braden Scale for Predicting Pressure Ulcers dated 9/24/25, identified a score of 12 which indicated high risk. R3's Wound RN Assessment dated 10/2/25, identified a stage I pressure ulcer on the sacrum that measured 1 cm x 1 cm. The wound was described as an open area. R3's, Wound Data Collection dated 10/24/25. identified an open area on the coccyx that measured 1 cm x .5 cm. No drainage or bleeding identified. Surrounding tissue pink and intact. Wound bed 100% epithelialized (a newly formed layer of epithelial cells that regenerates to cover a wound surface, typically appearing translucent and lighter in color), indicating a stage II pressure ulcer. Wound margins or surrounding skin indicated it was denuded (skin that had the first protective layer removed). R1's medical record lacked evidence of wound assessments between 10/2/25 and 10/24/25. During interview on 10/31/25 at 10:27 a.m., licensed practical nurse (LPN)-A said R3 normally did not have a lot of skin issues but said currently they had been monitoring a little pressure sore on his coccyx. LPN-A said she had seen it a few weeks ago and it was the size of a dime.	20830		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER: **Good Samaritan Society - Blackduck**		STREET ADDRESS, CITY, STATE, ZIP CODE: **172 SUMMIT AVENUE WEST , BLACKDUCK, Minnesota, 56630**	

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20830	Continued from page 6 During interview on 10/31/25 at 11:55 a.m., RN-B said "we have some issues with our wound charting." RN-B said the goal was to set aside a day each week to have two nurses look at the wounds, but it had not been implemented yet. 10/31/25 at approximately 1:00 p.m., the director of nursing (DON) said if a wound was observed, staff should complete the data collection form and an RN should complete the assessment if the initial assessment was completed by an LPN. The DON sated the facility did not have a process for regular wound rounds. The DON further stated nurses were supposed to complete skin checks weekly on bath day and acknowledged R3's skin checks were not being completed. Facility Policy Skin Assessment Pressure Ulcer Prevention and Documentation Requirements dated 4/6/25, indicated if a pressure ulcer was identified, the RN should record the type of wound and the degree of tissue damage on the Wound RN Assessment. The licensed nurse records the location, area, measurements and the ulcer/wound characteristics on the Wound Data Collection assessment. Pressure ulcers should be evaluated at least weekly. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could 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 could 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.	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245600	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER: Good Samaritan Society - Blackduck	STREET ADDRESS, CITY, STATE, ZIP CODE: 172 SUMMIT AVENUE WEST , BLACKDUCK, Minnesota, 56630		

(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
F0000	INITIAL COMMENTS On 10/30/25 through 10/31/25, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H56006603C (265369 with deficiencies issued at F641, F655, F686. 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.	F0000		12/15/2025
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of	F0641	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. F641 Accuracy of Assessments. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R1's was transferred to the hospital on 10/24/2025 and did not return to the facility. As a result we were	12/26/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245600**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/31/2025**

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Good Samaritan Society - Blackduck	**172 SUMMIT AVENUE WEST , BLACKDUCK, Minnesota, 56630**

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F0641 SS = D	Continued from page 1 that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect pressure ulcer staging for 1 of 3 residents (R1) reviewed with pressure ulcers. Findings include: R1's Admission Record indicated she admitted to the facility on 10/16/25. R1's diagnosis included dehydration, Parkinson's disease, anxiety and weakness. R1's Braden Scale for Predicting Pressure Sore Risk dated 10/16/25, indicated a score of 13, which indicated moderate risk. R1's Wound Data Collection dated 10/16/25 at 5:15 p.m., identified an unstageable decubitus (a type of skin injury caused by prolonged pressure on the skin, which restricts blood flow and can lead to tissue damage and death) ulcer on the left buttock that measured 3 centimeters (cm) x .75 cm. Surrounding skin pink and intact. Wound bed 100% granulation tissue (described as being red and moist, with a bumpy or granular appearance due to new capillary buds, fibroblasts, and collagen), which indicated a stage III pressure ulcer. Wound margins were intact and pink. R1's Wound Data Collection dated 10/16/25 at 5:24 a.m., identified a wound (no description) on the left iliac crest (the curved area on the sides of the hip bones of the pelvic girdle) that measured 3.5 cm x 1 cm x .75 cm. Drainage present on dressing, surrounding tissue	F0641	Continued from page 1 unable to reassess to ensure accurate pressure ulcer staging and MDS coding. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents with wounds have the potential to be affected by the deficient practice. As a result, all residents assessed as having wounds will be reassessed to ensure accurate pressure ulcer staging and that accurate staging is reflected on the MDS assessment. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure compliance is sustained, DNS/designee will educate all licensed and registered nursing staff on Wound Care to include documentation, wound etiology, types of wounds, pressure injury staging, anatomical location, prevention measures, Braden Scale Interventions, Nursing Admission/Readmission Data Collection, care planning, wound care in the context of enhanced barrier precautions, tips for wound dressing changes, tips for preventing cross-contamination in wound care. DNS will review Good Samaritan policy on assessments 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? The corrective action will be monitored by the DNS/designee completing audits on all residents with wounds along with new admissions/readmissions weekly to ensure accurate pressure ulcer staging and that accurate staging is reflected on the MDS assessment. These audits will review Nursing Admission/Readmission Data Collection, Braden Scale, Skin Observations, Wound Data Collection, RN Wound Assessment, Care Plan and Interventions. Audit results will be brought to the QAPI committee for input on the need to increase, decrease or discontinue audits. 5. What is the date of completion? Compliance date: 12/26/2025	

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F0641 SS = D	Continued from page 2 intact and tunneling (a chronic wound with an opening that extends into a narrow passageway or channel beneath the skin's surface) present. Wound characteristic not completed. Drainage amount indicated moderate, color indicated purulent (white, yellow, green, brown, or sometimes pink-tinged). R1's Wound RN (registered nurse) Assessment dated 10/16/25 at 5:32 a.m., indicated an unstageable pressure ulcer to the left buttock, present on admission. The assessment indicated, continue with current plan of treatment. R1's Wound Data Collection dated 10/22/25 at 8:09 a.m., identified a stage I pressure ulcer (the earliest stage of a pressure injury, characterized by reddened, unbroken skin that does not turn white when pressed) to the left buttock that measured 3 cm x .35 cm. Wound characteristics indicated 100% granulation tissue. Surrounding tissue identified as macerated (softened, wrinkled tissue due to moisture) and reddened. RN to assess change in wound status. R1's Wound Data Collection dated 10/22/25 at 11:50 a.m., identified a wound on the coccyx (the final bone at the bottom of the spine) that measured 2.5 cm x 1 cm. Description was left blank. Wound characteristics indicated 100% granulation tissue. Surrounding tissue macerated and reddened. RN to assess change in wound status. R1's Wound RN assessment dated 10/23/25 at 3:40 p.m., identified a non-pressure related wound on the iliac crest. Tissue loss indicated full thickness loss (a severe wound that extends through all layers of the skin and into underlying structures like fat, muscle, tendon, or bone). Physician was notified regarding wound status, requesting wound consult. R1's Wound RN Assessment dated 10/23/25 at 3:42 a.m., identified an unstageable pressure ulcer on the left buttock. During interview on 10/31/25 at 11:55 a.m., RN-B indicated she was new to her role and stated when coding the MDS, she looked at the nursing data collection. RN-B said the data collection she looked at said R1 had an unstageable pressure ulcer on admission which was why she coded it that way. RN-B said there were some issues with the facilities wound charting.	F0641		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F0655	F655 Baseline Care Plan. 1. What corrective action will be accomplished for	12/26/2025

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NAME OF PROVIDER OR SUPPLIER: **Good Samaritan Society - Blackduck**		STREET ADDRESS, CITY, STATE, ZIP CODE: **172 SUMMIT AVENUE WEST , BLACKDUCK, Minnesota, 56630**	

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F0655 SS = D	Continued from page 3 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by	F0655	Continued from page 3 those residents found to have been affected by the deficient practice? R1's was transferred to the hospital on 10/24/2025 and did not return to the facility. As a result we were unable to review/revise this residents care plan to include instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents with skin issues including wounds have the potential to be affected by the deficient practice. As a result, the care plans for all residents assessed as having skin issues/wounds and all new admissions/readmissions will be reviewed/revised to ensure instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure compliance is sustained, The facilities CarePlan-RS, LTC, Therapy & Rehab Policy was reviewed and Licensed and Registered Nurses will be educated on this policy. All licensed and registered nursing staff will be trained on Wound Care to include documentation, wound etiology, types of wounds, pressure injury staging, anatomical location, prevention measures, Braden Scale Interventions, Nursing Admission/Readmission Data Collection, care planning, wound care in the context of enhanced barrier precautions, tips for wound dressing changes, tips for preventing cross-contamination in wound care. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? The corrective action will be monitored by the DNS/designee completing audits on all residents with wounds along with new admissions/readmissions weekly to ensure residents wounds have been assessed, and care plans include instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. These audits will review Nursing Admission/Readmission Data	

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F0655 SS = D	Continued from page 4 the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure a baseline care plan related to pressure ulcers was developed for 1 of 3 resident (R1) who admitted to the facility with a pressure ulcer and developed pressure ulcers. Findings include: R1's Admission Record indicated she admitted to the facility on 10/16/25. R1's diagnosis included dehydration, Parkinson's disease, anxiety and weakness. R1's Braden Scale for Predicting Pressure Sore Risk dated 10/16/25, indicated a score of 13, which indicated moderate risk. R1's Wound Data Collection dated 10/16/25 at 5:15 p.m., identified an unstageable decubitus (a type of skin injury caused by prolonged pressure on the skin, which restricts blood flow and can lead to tissue damage and death) ulcer on the left buttock that measured 3 centimeters (cm) x .75 cm. Surrounding skin pink and intact. Wound bed 100% granulation tissue (described as being red and moist, with a bumpy or granular appearance due to new capillary buds, fibroblasts, and collagen), which indicated a stage III pressure ulcer. Wound margins were intact and pink. R1's Wound Data Collection dated 10/16/25 at 5:24 a.m., identified a wound (no description) on the left iliac crest (the curved area on the sides of the hip bones of the pelvic girdle) that measured 3.5 cm x 1 cm x .75 cm. Drainage present on dressing, surrounding tissue intact and tunneling (a chronic wound with an opening that extends into a narrow passageway or channel beneath the skin's surface) present. Wound characteristic not completed. Drainage amount indicated moderate, color indicated purulent (white, yellow, green, brown, or sometimes pink-tinged). R1's Wound RN (registered nurse) Assessment dated 10/16/25 at 5:32 a.m., indicated an unstageable pressure ulcer to the left buttock, present on admission. The assessment indicated, continue with current plan of treatment.	F0655	Continued from page 4 Collection, Braden Scale, Skin Observations, Wound Data Collection, RN Wound Assessment, Care Plan and Interventions. Audit results will be brought to the QAPI committee for input on the need to increase, decrease or discontinue audits. 5. What is the date of completion? Compliance date: 12/26/2025	

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F0655 SS = D	Continued from page 5 R1's Wound Data Collection dated 10/22/25 at 8:09 a.m., identified a stage I pressure ulcer (the earliest stage of a pressure injury, characterized by reddened, unbroken skin that does not turn white when pressed) to the left buttock that measured 3 cm x .35 cm. Wound characteristics indicated 100% granulation tissue. Surrounding tissue identified as macerated (softened, wrinkled tissue due to moisture) and reddened. RN to assess change in wound status. R1's Wound Data Collection dated 10/22/25 at 11:50 a.m., identified a wound on the coccyx (the final bone at the bottom of the spine) that measured 2.5 cm x 1 cm. Description was left blank. Wound characteristics indicated 100% granulation tissue. Surrounding tissue macerated and reddened. RN to assess change in wound status. R1's Wound RN assessment dated 10/23/25 at 3:40 p.m., identified a non-pressure related wound on the iliac crest. Tissue loss indicated full thickness loss (a severe wound that extends through all layers of the skin and into underlying structures like fat, muscle, tendon, or bone). Physician was notified regarding wound status, requesting wound consult. R1's Wound RN Assessment dated 10/23/25 at 3:42 a.m., identified an unstageable pressure ulcer on the left buttock. R1's Nursing Admit Re-Admit Data Collection dated 10/16/25, indicated skilled services to include wound care. Skin integrity assessment indicated a dehisced (partial or total separation of previously approximated wound edges, due to a failure of proper wound healing) scar on the left side of her abdomen, left buttock: crease area unstageable ulcer due to previous location and a scratch on her arm. R1's care plan dated 10/16/25, identified a self-care deficit related to weakness. The care plan directed staff to assist with bed mobility, transfers and toilet use. The care plan identified a potential and actual impairment to skin integrity and open wounds and an unstageable pressure ulcer on the left buttock. The care plan directed staff to monitor size, location and treatment of skin injury, provide pressure relieving device and or skin protective device (unspecified), on heels, elbows, etcetera (not specified). Frequency not specified. The care plan indicated avoid positioning on back. R1's care plan identified Parkinson's disease and indicated, monitor voiding pattern and continence and implement toileting program if needed.	F0655		

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F0655 SS = D	Continued from page 6 During interview on 10/31/25 at approximately 1:00 p.m., the director of nursing (DON) acknowledged R1 did not have a baseline care plan and stated the initial care plan was done with assessments and said the nurses can click buttons to add interventions to the care plan. The DON said the nurses must not have clicked the buttons on the assessments to link to the care plan. The DON stated after the initial care plan the MDS coordinator, RN-B completed the care plans. Facility policy Care Plan dated 12/2/24, indicated the baseline care plan includes instructions needed to provide effective and person-centered care of the resident that met professional standards of quality of care. The policy indicated each resident will have and individualized, person-centered, comprehensive care plan to include measurable goals and timetables directed toward achieving and maintaining the residents optimal medical, nursing, physical and functional needs. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument and review of physician orders.	F0655		
F0686 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 interview and document review the facility failed to perform ongoing and accurate assessment of pressure ulcers for 2 of 3 residents (R1,R3) who were at risk for pressure ulcer development. In addition, the facility failed to implement interventions to reduce the risk for new or worsening pressure ulcers.	F0686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R1's was transferred to the hospital on 10/24/2025 and did not return to the facility. As a result we were unable to review/revise this residents care plan to include instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. R3 was reassessed to identify risk for pressure ulcer development. R3's care plan was reviewed/revised to include interventions to reduce the risk for new or worsening pressure ulcers. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents at risk for skin breakdown have the potential to be affected by the deficient practice. As a result, the care plans for all residents assessed as having skin/wounds will be reviewed/revised to ensure interventions are in place to reduce the risk for new or worsening pressure ulcers.	12/26/2025

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F0686 SS = D	Continued from page 7 Findings include: R1's Admission Record indicated she admitted to the facility on 10/16/25. R1's diagnosis included dehydration, Parkinson's disease, anxiety and weakness. R1's Braden Scale for Predicting Pressure Sore Risk dated 10/16/25, indicated a score of 13, which indicated moderate risk. R1's Nursing Admit Re-Admit Data Collection dated 10/16/25 at 4:33 p.m., indicated skilled services to include wound care. Skin integrity assessment indicated a dehisced (partial or total separation of previously approximated wound edges, due to a failure of proper wound healing) scar on the left side of her abdomen, left buttock: crease area unstageable ulcer due to previous location and a scratch on her arm. R1's Wound Data Collection dated 10/16/25 at 5:15 p.m., identified an unstageable decubitus (a type of skin injury caused by prolonged pressure on the skin, which restricts blood flow and can lead to tissue damage and death) ulcer on the left buttock that measured 3 centimeters (cm) x .75 cm. Surrounding skin pink and intact. Wound bed 100% granulation tissue (described as being red and moist, with a bumpy or granular appearance due to new capillary buds, fibroblasts, and collagen), which indicated a stage III pressure ulcer. Wound margins were intact and pink. R1's Wound Data Collection dated 10/16/25 at 5:24 a.m., identified a wound (no description) on the left iliac crest (the curved area on the sides of the hip bones of the pelvic girdle) that measured 3.5 cm x 1 cm x .75 cm. Drainage present on dressing, surrounding tissue intact and tunneling (a chronic wound with an opening that extends into a narrow passageway or channel beneath the skin's surface) present. Wound characteristic not completed. Drainage amount indicated moderate, color indicated purulent (white, yellow, green, brown, or sometimes pink-tinged). R1's Wound RN (registered nurse) Assessment dated 10/16/25 at 5:32 a.m., indicated an unstageable pressure ulcer to the left buttock, present on admission. The assessment indicated, continue with current plan of treatment. R1's Wound Data Collection dated 10/22/25 at 8:09 a.m., identified a stage I pressure ulcer (the earliest stage of a pressure injury, characterized by reddened, unbroken skin that does not turn white when pressed) to	F0686	Continued from page 7 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure compliance is sustained, The DNS/designee will educate staff on Skin Assessment Pressure Ulcer Prevention and Documentation Requirements – Rehab/Skilled, Therapy & Rehab Policy was reviewed, and all Licensed and Registered Nurses will be educated on this policy. All licensed and registered nursing staff will be trained on Wound Care to include documentation, wound etiology, types of wounds, pressure injury staging, anatomical location, prevention measures, Braden Scale Interventions, Nursing Admission/Readmission Data Collection, care planning, wound care in the context of enhanced barrier precautions, tips for wound dressing changes, tips for preventing cross-contamination in wound care. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? The corrective action will be monitored by the DNS/designee completing audits on all residents with wounds along with new admissions/readmissions weekly to ensure residents wounds have been assessed, and care plans include interventions to reduce the risk for new or worsening pressure ulcers. These audits will review Nursing Admission/Readmission Data Collection, Braden Scale, Skin Observations, Wound Data Collection, RN Wound Assessment, Care Plan and Interventions. Audit results will be brought to the QAPI committee for input on the need to increase, decrease or discontinue audits. 5. What is the date of completion? Compliance date: 12/26/2025	

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Good Samaritan Society - Blackduck	**172 SUMMIT AVENUE WEST , BLACKDUCK, Minnesota, 56630**

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F0686 SS = D	Continued from page 8 the left buttock that measured 3 cm x .35 cm. Wound characteristics indicated 100% granulation tissue. Surrounding tissue identified as macerated (softened, wrinkled tissue due to moisture) and reddened. RN to assess change in wound status. R1's Wound Data Collection dated 10/22/25 at 11:50 a.m., identified a wound on the coccyx (the final bone at the bottom of the spine) that measured 2.5 cm x 1 cm. Description was left blank. Wound characteristics indicated 100% granulation tissue. Surrounding tissue macerated and reddened. RN to assess change in wound status. R1's Wound RN assessment dated 10/23/25 at 3:40 p.m., identified a non-pressure related wound on the iliac crest. Tissue loss indicated full thickness loss (a severe wound that extends through all layers of the skin and into underlying structures like fat, muscle, tendon, or bone). Physician was notified regarding wound status, requesting wound consult. R1's Wound RN Assessment dated 10/23/25 at 3:42 a.m., identified an unstageable pressure ulcer on the left buttock. R1's care plan dated 10/16/25, identified a self-care deficit related to weakness. The care plan directed staff to assist with bed mobility, transfers and toilet use. The care plan identified a potential and actual impairment to skin integrity and open wounds and an unstageable pressure ulcer on the left buttock. The care plan directed staff to monitor size, location and treatment of skin injury, provide pressure relieving device and or skin protective device (unspecified), on heels, elbows, etcetera (not specified). Frequency not specified. The care plan indicated avoid positioning on back. R1's care plan identified Parkinson's disease and indicated. monitor voiding pattern and continence and implement toileting program if needed. R1's Kardex (care guide) dated 10/31/25, lacked direction to staff related to mobility, transfers and frequency of repositioning or toileting. R1's discharge Minimum Data Set (MDS) dated 10/24/25, identified an unstageable deep tissue injury, present on admission. R1's Progress Notes identified the following: 10/17/25, Daily vitals, medication administration, dressing changes. Wound still open, no swelling or redness surrounding (wound location not identified).	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245600	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2025

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F0686 SS = D	Continued from page 9 Transfer assist of two with mechanical lift. 10/19/25, R1 intermittently incontinent of large amounts of urine and required a full bed change over the past three overnight shifts. 10/20/25, Daily vitals, medication administration, dressing changes. Wound is still open, no swelling or redness (wound location not identified). 10/21/25, Daily vitals, medication administration, dressing changes. Wound is still open, no swelling or redness (wound location not identified). 10/22/25, R1 had a 10 cm diameter reddened coccyx and buttocks. 10/22/25, R1 did not want to get out of bed. staff did frequent position changes. 10/23/25, Small red area on sternum. 10/24/25, R1 discharged to the hospital due to altered mental status. During interview on 10/30/25, at 2:09 p.m., R1's significant other (SO) stated every time he visited R1 at the facility she had been incontinent of bowel and not cleaned up. He said R1 was lying in feces every time he visited and said the time varied. The SO said R1 was currently in the hospital and was "covered in sores." SO said when R1 admitted to the facility her sores had been healed up. The SO stated, "I couldn't believe it when she got to the hospital and saw all of the sores." During interview on 10/31/25 at 10:27 a.m., licensed practical nurse (LPN)-A said skin assessments were completed every week on bath day. LPN-A said if a skin concern was identified it was noted and if no skin check was noted there was a spot on the form to indicate the skin check had been completed. LPN-A said R1 had multiple skin concerns, one on her abdominal fold and her coccyx. LPN-A said those were the wounds that had daily dressings. LPN-A said the wound on R1's coccyx was about the size of a quarter, red with blood-tinged fluid and looked like shearing (type of skin injury caused by opposing forces pulling on the skin and underlying tissues, often resulting in damage to deeper layers of skin and tissue). The abdominal fold was red and open, kind of "oozy" with clear drainage and about the size of a dime. LPN-A said she remembered a wound on the left buttock but did not recall what it looked like.	F0686		

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F0686 SS = D	Continued from page 10	F0686		

On 10/31/25 at 11:21 a.m., NA-A and NA-B were interviewed. NA-A said they used the Kardex to determine how the care for the residents. NA-A said they had assignment sheets also because things changed often. If a new admission, NA-A said they asked the nurse for the information. NA-B said R1 had a lot of loose stools so she was changed every two hours and cream was applied. NA-B said she got "pretty raw." NA-A said R1's coccyx was very red. NA-A said R1 always had a heated blanket on her chest and got a bigger sore that was red.

During interview on 10/31/25 at 11:46 a.m., RN-A said she had not completed any of R1's wound assessments but had addressed the wound in progress notes. RN-A said R1 had two or three openings on the left side under her abdominal folds that had dressings placed on them. RN-A said R1 also had a wound on her coccyx, one on the gluteal cleft and one on her labia. RN-A said she had seen the wounds the day before R1 went to the hospital. RN-A said the labia wound looked like a scratch and said R1 had lines in her skin like her incontinent brief had been too tight. The gluteal cleft was described as a stage I, the top layer of skin was missing. RN-A described the coccyx wound as an opening with the top layer of skin missing. RN-A said R1's sternum was very prominent and said it looked her gown was always rubbing on it. She said R1 had a wound about the size of the tip of a pinky finger on her chest.

R3's Admission Record indicated he admitted to the facility 9/14/21. Diagnosis included dementia, heart disease, pain and history of falls.

R3's care plan dated 6/5/25, identified limited physical mobility, and a self-care deficit and incontinence related to deconditioning. The care plan indicated R3 required the use of a mechanical lift for transfers and required assistance from staff for bed mobility and toileting. The care plan directed staff to check every two to three hours for incontinence. The care plan further identified an alteration in skin integrity related to reduced physical mobility and directed staff to assist to turn and reposition frequently during the day and at 12:00 a.m. and 4:00 a.m., use of a pressure reducing mattress and protective boots at night.

R3's Braden Scale for Predicting Pressure Ulcers dated 9/24/25, identified a score of 12 which indicated high

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F0686 SS = D	Continued from page 11 risk. R3's Wound RN Assessment dated 10/2/25, identified a stage I pressure ulcer on the sacrum that measured 1 cm x 1 cm. The wound was described as an open area. R3's, Wound Data Collection dated 10/24/25. identified an open area on the coccyx that measured 1 cm x .5 cm. No drainage or bleeding identified. Surrounding tissue pink and intact. Wound bed 100% epithelialized (a newly formed layer of epithelial cells that regenerates to cover a wound surface, typically appearing translucent and lighter in color), indicating a stage II pressure ulcer. Wound margins or surrounding skin indicated it was denuded (skin that had the first protective layer removed). R1's medical record lacked evidence of wound assessments between 10/2/25 and 10/24/25. During interview on 10/31/25 at 10:27 a.m., licensed practical nurse (LPN)-A said R3 normally did not have a lot of skin issues but said currently they had been monitoring a little pressure sore on his coccyx. LPN-A said she had seen it a few weeks ago and it was the size of a dime. During interview on 10/31/25 at 11:55 a.m., RN-B said "we have some issues with our wound charting." RN-B said the goal was to set aside a day each week to have two nurses look at the wounds, but it had not been implemented yet. 10/31/25 at approximately 1:00 p.m., the director of nursing (DON) said if a wound was observed, staff should complete the data collection form and an RN should complete the assessment if the initial assessment was completed by an LPN. The DON sated the facility did not have a process for regular wound rounds. The DON further stated nurses were supposed to complete skin checks weekly on bath day and acknowledged R3's skin checks were not being completed. Facility Policy Skin Assessment Pressure Ulcer Prevention and Documentation Requirements dated 4/6/25, indicated if a pressure ulcer was identified, the RN should record the type of wound and the degree of tissue damage on the Wound RN Assessment. The licensed nurse records the location, area, measurements and the ulcer/wound characteristics on the Wound Data Collection assessment. Pressure ulcers should be evaluated at least weekly.	F0686		