STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355 Based on observation, interview, and document review the facility failed to compressively assess falls for root cause, implement appropriate interventions and follow the care plan to prevent and/or reduce the risk of falls with major injury 2 of 2 residents (R2 and R3) with history of falls. This resulted in immediate jeopardy (IJ) for R2 who sustained multiple left rib fractures, left clavicle fracture and a subdural hematoma (brain bleed). The IJ began on 7/27/24 when staff failed to implement R2's care plan for close supervision resulting in R2's fifth (5th) unwitnessed fall, major head injury, and intensive care unit (ICU) admission. The administrator, regional nurse manager, and director of nursing (DON) were notified of the IJ on 8/2/24 at 3:00 p.m. The IJ was removed on 8/3/24 at 12:00 p.m., when the facility had implemented immediate corrective action to prevent recurrence, but noncompliance remained at a lower scope and severity of a D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings included: R2's admission Minimum Data Set (MDS) dated [DATE], identified R2 did not have cognitive impairment and had diagnoses of hip fracture, other fracture, osteoporosis, and dementia. R2 had a history of falls prior to admission to the facility and two falls with injury since admission on 7/1/24. R2 had functional range of motion impairment on one upper and lower extremity. R1 used a walker and wheelchair. R2 required partial to substantial assistant for all his activities of daily living (ADLs) and required moderate assist for transfers and did not walk more than 10 feet. R2 was frequently incontinent of bowel and bladder and did not have a toileting plan. Review of R2's Fall Tool admission assessment dated [DATE], R2 was at medium risk for falls. R2 had history of one or more falls in the last three months, was taking medications that put him at risk, and mildly impaired cognition status. R2 risk factor for falls included mobility/transfers due to changes in mobility related to muscles weakness or strength, impaired balance or coordination and pain. Although R2 had mild cognition he had reduced insight, difficulties in orientation on new admission, medical problems which affected changes in his orientation/level of consciousness and was incontinent. R2 was referred to therapy and care plan was updated. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's care plan dated 7/2/24, included an ADL focus that indicated R2 had a deficit related to recent hip surgery with interventions that directed to use one staff assistance with pivot/transfers. Fall focus identified R2 had an actual fall on 7/1/24 (sic) and was at risk for falls related to falls prior to hospitalization with the intervention that directed staff to ensure R2 was wearing appropriate footwear when ambulating or mobilizing in wheelchair. The care plan also identified R2's preferred wake time was 5:00 a.m. and his bedtime was 10:00 p.m. The care plan did not identify a toileting routine or program even though R2 was frequently incontinent of urine. R2's late entry progress note dated 7/3/24 at 11:42 a.m., indicated R2 was heard yelling from hallway. R2 was found lying across the bedside table legs, R2's head was facing the door and head at the foot of the bed and nightstand. Water pitcher and water spilled on the floor. R2 did not have shoes on. Skin tear noted to left elbow with complaints of pain in left shoulder, unable to abduct without pain or calling out. Pillow placed under head and removed bedside stand from under body. Vital signs obtained and transfer to emergency department (ED) initiated. Ambulance arrived at 8:10 a.m. and left 8:15 a.m. Progress note at 11:20 a.m. indicated the hospital ED called the facility to notify R2 had fractured his left scapula and several ribs on the left side. R2's Fall Huddle Sheet dated 7/3/24 at 7:50 a.m., identified the fall with the additional information of- R2 was ambulating and attempting to self-transfer, slipped and lost his balance. R2's bed was higher than it should have been and R2 had bare feet. Last toileted at 1:43 a.m. six hours before R2's fall. R2's incident report dated 7/3/24 at 7:50 a.m., included the fall information identified in the progress note and Fall Huddle with the following additional information: R2 had on brief and t-shirt, R2 recently had right hip replacement, which he was able to move appropriately, and R2 stated that he was getting up to go take a shower initially and then later thought he was in the copy/print room at his newspaper job in Colorado. R2's records did not include a comprehensive fall analysis for root cause and interventions that identified risk factors from the incident and huddle reports such as (but not limited) to the bed height, self-transfers/impulsivity, and duration of time documented between toileting. R2's progress note dated 7/9/24, identified R2 returned from the hospital and his care plan was updated with interventions to reduce the risk for falls. R2's care plan was revised on 7/8/24 to reflect the following interventions, educate resident not to bend over to pick up dropped items. Encourage use of grabber or to ask for assistance. R2's care plan was revised on 7/9/24 to reflect the following interventions: Make sure resident wears glasses when up/out of bed; Keep urinal within reach, check and empty frequently (frequency was not defined); Fall mat placed on floor next to bed; signs placed in room to remind R2 to use call light and wait for assistance. Staff to ask for OT to evaluate room arrangement and will trial non-spill cup that R2 can keep in bed with him. New focuses added included: R2 had sleep disturbance evidenced by complaints of feeling tired, change in ability to perform ADLs, and change in gait/falls with interventions that included follow R2's usual bedtime routine. New focus of R2 had behavior symptoms evidenced by impulsiveness and lack of safety awareness with interventions that included praise any indication of R2's progress/improvement in behavior and prefers the diversional activity of ready books. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R2's record between 7/9/24 to 7/22/24, did not indicate OT had completed an evaluation of R2's room arrangement. R2's progress note dated 7/10/24 at 7:00 p.m., identified background, assessment, and recommendation (SBAR) was sent to physician indicating R2 had fallen when he went to stand up. Was wearing appropriate footwear and had call light and personal items within reach. At 7:25 p.m. R2 was sent to the ED via ambulance. R2 had head computer tomography (CT) without evidence of injury or bleed and laceration on right side of forehead. R2's Fall Huddle Sheet dated 7/10/24 at 7:00 p.m., identified the fall information and included the additional information of- fall was unwitnessed. R2 reported he was trying to stand up to empty his urinal and lost his balance. Causal factors included the bed/chair height was not appropriate and R2 does not ask for assistance. R2's incident report dated 7/10/24 at 7:00 p.m., identified the aforementioned fall information from the Fall Huddle and progress notes. Additional information included: Urinal was of dresser and only 1/3 full; R2 seemed confused on where he was and what he was doing; impaired memory and lack of safety awareness put him at increased risk for falls. The incident report was updated on 7/15/24 included Have been constantly reminding resident to wait for assistance, and this has been helping. R2's records did not identify a comprehensive fall analysis for root cause that addressed risk factors identified on the incident and huddle reports such as (but not limited to) height of the bed, urinal usage, and self-transfers/impulsivity. R2's ED notes dated 7/10/24, identified R2 presented after a fall with a laceration to his scalp that was 2 centimeters (cm) on his right forehead near the hairline that required sutures. We recommend tabs alarm [a device that alarms audibly or silently (i.e. box at nursing desk) with movement of resident from a surface such as a bed or chair] or closer supervision to prevent falls. R2's progress note dated 7/10/24 at 10:26 p.m. indicated director of nursing (DON) had concerns with R2 returning to the facility. DON informed them [hospital] that nursing home unable to provide 1:1 supervision with resident d/t [do to] staffing and TABS are not appropriate in this setting. MD stated no medical reason for hospitalization , R2 would be returning to facility. R2's progress note dated 7/10/24 at 11:30 p.m. indicated R2 arrived back to the facility from ED with no acute pathology and received orders for TABS alarm at all times if possible or supervision. DON explained that TABS alarms are not used at the facility d/t it being considered a restraint .actually create a fall . Facility to provide increased supervisor of resident by having resident in recliner chair out by nurse's station so his safety can be closely monitored by staff. R2's care plan was revised on 7/11/24, to include Ensure/provide a safe environment: avoid isolation and place resident by chair by nurse's station to offer closer supervision as ordered by the physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's record did not identify an assessment that determined and/or defined frequency of checks/supervision R2 required based on his risk factors, mannerisms, and behaviors. Furthermore, there was no indication the medically recommended device (tabs) based on a physician's evaluation to prevent R2 falls was comprehensively assessed by the facility prior to the determining the device would not be effective. Review of R2's record between 7/11/24 to 7/29/24, there was no indication R2's care plan interventions that directed staff to provide closer supervision and placing R2 by the nurse's stations were implemented and/or evaluated for effectiveness. R2's progress note dated 7/14/24 at 3:00 p.m., indicated R2 had an unwitnessed fall in his room. Staff found R2 on the floor with head on dresser and feet towards bed. Staff assisted R2 to wheelchair and out to lounge area. R2 stated he wanted to go to the basement. R2 noted to transfer self during morning shift to bathroom and to recliner after dinner. R2 was asked if attempted to ambulate self and replied yes, because I don't need any help. Review of R2's Fall Huddle Sheet dated 7/14/24 at 3:00 p.m. identified the fall information with the additional information of- causal factors included R2 gets more confused @ night Corrective actions taken: Resident education/training or re-instruction. No care plan interventions were identified. R2's incident report dated 7/14/24 at 3:00 p.m., identified the fall information. Additional information included-Resident alert and orientated x 3 during the day but as time gets later, he gets more confused. The report was updated on 7/15/24 to include, the interdisciplinary team (IDT) reviewed Incident: Intervention will be to put a sign in his room. Resident loves to read, so we are thinking this will be a better intervention that constant telling him to Wait for help In review of R2's records identified a comprehensive fall analysis for root cause and interventions was not completed that addressed risk factors included on the incident and huddle reports such as (but not limited to) even though the reports identified R2 had increased confusion at night, the intervention for closer supervision was not individualized and/or assessed to address that risk factor. Additionally, not evident the care plan was revised to include signage intervention. R2's progress note dated 7/16/24 at 2:45 a.m., staff was going down hallway and noticed R2's door closed, stopped to open, and found R2 lying on the floor stretched out next to his bedside. Had a smile on his face and denied any new pain. R2 states he slipped off the edge of his bed. R2 was assisted off the floor. Bed was lowered to lowest position and fall mat applied to floor at bedside. Call light within reach. Review of R2's Fall Huddle Sheet dated 7/16/24 3:19 a.m., identified fall information in addition to R2 stated he fell while trying to reach his water. Action taken was water glass in bed no spill cup No injuries. R2's incident report dated 7/16/24 at 3:19 a.m., identified fall information with no other additional information. The report was updated on 7/22/24 to include IDT reviewed Incident: Will attempt to give resident a new cup that won't spill and he can keep closer to himself in bed. Also, will talk to therapy to check out resident's room to see if we can rearrange to make it easier for Resident to navigate (according to the care plan both interventions were supposed to be already in place on 7/9/24). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R2's record lacked a comprehensive analysis of causal factors that included if the intervention of close supervision was provided and was evaluated for effectiveness. Further not evident the care plan was revised to reduce R2's risk for falls and/or falls with major injury. R2's progress note dated 7/27/24 at 6:00 p.m., nursing assistant observed R2 on floor by closet door with head towards his bed. ROM within normal limits, pupils equal and reactive to light, assist with two staff to wheelchair without difficulty and taken to lounge area to watch TV with other residents. Nurse noted a bump to left side of head in which R2 refused an ice pack, also noted a blood blister on left elbow, covered with band aid. Facility surveillance video footage recorded on 7/27/24 from 5:55 p.m. to 6:19 p.m. was reviewed with the administrator. -At 5:56 p.m. licensed practical nurse (LPN)-B walked by R2's room. LPN-B looked in the room but did not stop. LPN-B assisted a female resident to her room at the end of the hallway. -At 5:59 p.m. LPN-B walked back up the hallway and entered R2's room for approximately 15 seconds and then exits the room without R2. -At 6:09 p.m. NA-P walked down hallway and looked in R2's room, entered the room, and activated the emergency call light. NA-Z and LPN-B walked to and entered R2's room. -At 6:11 p.m., NA-Z left R2's room and walked towards the nursing station. NA-P left the room, got the standing mechanical lift from the other end of the hallway, and brought it back to R2's room along with wheelchair at 6:14 p.m. -At 6:16 p.m., NA-P exited R2's room with the standing lift. -At 6:19 p.m., LPN-K exited the room, looked to be prompting R2 to follow her, R2 self-propelled his wheelchair out of the room toward the nurse's station. Review of R2's Fall Huddle Sheet dated 7/27/24 at 6:00 p.m., R2 had an unwitnessed fall in his room when he was ambulating to bathroom using a device (not specified). Last seen by a staff member around 5:30 p.m. Causal factors included resident left in room unattended. The form indicated the investigation was completed on 7/29/24. Corrective action taken was documented as the roommate moved to a different room to make R2's room private and staff suspension/terminated. R2's incident report dated 7/27/24 6:00 p.m., identified the fall information. In addition, R2 reported I was just walking. The form was revised on 7/29/24 to include IDT Team reviewed incident: Noted that Roommates walker was next to him after fall. Intervention: Ensure roommate's walker is out of reach and out of the way to ensure R2 does not attempt to use it. R2's progress notes on 7/29/24 at 8:04 a.m., indicated a nurse was called to R2's room. R2 was orientated to self only. The physician and power of attorney were notified. Progress note at 8:16 a.m. indicated an order to send R2 to ED. Progress note at 12:29 p.m. indicated the hospital ED called to notify facility compressions (cardio pulmonary resuscitation) was started. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's hospital progress note dated 7/29/24 indicated that R2 was being evaluated for a fall with head injury that occurred 3 days prior and at 8:30 a.m. on 7/29/24, was noted to be more confused and not following commands. R2's last known well time was 11:00 p.m. on 7/28/24. R2 had a head CT that showed 1.) an acute right subdural hematoma over the right vertebral hemisphere which measures up to 10 millimeters (mm) in thickness. A mild localized mass effect without midline shift. 2.) Hemorrhagic contusion most notable in the right temporal lobe, with a smaller hemorrhagic contusion involving the inferior right frontal lobe. 3.) Left parietal scalp trauma without associated skull fracture. During his ER stay R2 was transferred to higher level of care hospital by ground ambulance. R2's higher level hospital progress note dated 7/29/24, indicated R2 was admitted to the intensive Care Unit (ICU) with diagnoses of traumatic bran injury, sub [NAME] hematoma, temporal contusion, seizure, encephalopathy and hyponatremia. R2 had a repeat head CT upon arrival that agreed with the first hospital but added but added a thin subdural blood product along posterior falx (curved shape) and right tentorial leaflet, up to 1mm. R2 received antiseizure medications. During interview on 8/6/24 at 11:22, registered nurse (RN)-B reported R2 had been discharged from the hospital to a hospice facility however, was not aware of the date he was discharged . During an interview on 8/1/24 at 1:52 p.m., trained medication assistant (TMA)-A stated R2 had fallen a lot since admission. There was one fall where he fell and broke his shoulder and some ribs. TMA-A stated R2 would attempt to self-transfer and forget to ask for help. TMA-S stated if R2 was in his room staff needed to visualize R2 and make sure he was OK or R2 needed to be in the common area by nurses' station, so staff could see him. TMA-A indicated the checks were not documented anywhere. During an interview on 8/1/24 at 2:33 p.m., NA-B stated R2 had behaviors where he would get up by himself in his room then fall or wander around in his wheelchair. NA-B was not able to articulate R2's fall interventions. During an interview on 8/2/24 at 11:20 a.m., TMA-D stated R2 was alert and oriented. TMA-D remembered R2 had two falls while she was worker but could not recall the dates of the falls. TM-D explained R2 had slid out of his recliner after he had used the remote to raise the chair up too high. TMA-D could not remember what caused the other fall, but neither fall resulted in injuries. TMA-D could not remember R2's fall interventions. During an interview on 8/2/24 at 11:25 a.m., NA-J stated R2 would not listen; she would put R2 in his recliner with the reminder to use his call light however a few minutes later she would walk by his room to find R2 attempting to self transfer. NA-J remembered R2 had one fall while she was working. NA-J thought R2 was trying to self-transfer from his recliner to his wheelchair and got a goose egg on his forehead and a black eye. During an interview of 8/1/24 at 2:59 p.m., LPN-A stated R2 was a frequent faller, and was to be in the commons area by the nurse' station so staff could supervise him. LPN-A indicated she had been working on evening when R2 fell , LPN-A could not recall the date, she had opened R2's door and found R2 on the floor beside his bed with things under his head, like he had been there awhile. LPN-A stated R2 did not have any injuries with that fall and she had instructed staff working to leave R2's door open for closer monitoring when he was in bed. LPN-A indicated she had not added the intervention to R2's care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview of 8/1/24 at 3:20 p.m. NA-Z stated R2 was confused and did not use his call light and liked to be independent. NA-Z explained she had been working on 7/27/24, when R2 fall. NA-Z recalled the fall had happened and dinner and staff were busy with other residents. NA-Z had been talking with LPN-B by the dining room hallway when NA-P turned on the emergency call light. NA-Z got to R2's room with LPN-B and R2 had his head against the register under the window and R2's legs were entangled in a walker. NA-Z indicated she was not aware of how or why R2 was in his room unsupervised. During an interview on 8/2/24 at 8:15 a.m., NA-S stated R2 was impulsive and would not use his call light. According to R2's care plan he was supposed to be out at the nurse's station when he was out of bed, especially after meals. NA-S thought staff would forget this because R2 seemed like he was alert. On 7/29/24, NA-S went into get R2 up for the day around 8:00 a.m., and he was not responding like himself. R2 would respond verbally with yeah to her questions but would not move. NA-S sent NA-T for the nurse and LPN-K came and brought RN-B. R2 was sent to the local ER and then airlifted to a higher level of care. During interview on 8/2/24 at 11:51 a.m., LPN-B stated on 7/27/24, she was called to R2's room around 6:10 p.m. via the emergency staff alert. LPN-B entered R2's room and R2 was on the floor by the window and his head was not touching the wall or the floor. LPN-B stated she looked at R2's head and did not see any blood and R2 had answered her questions appropriately. LPN-B was not aware of how or why R2 was in his room alone. LPN-B stated on 7/29/24 at approximately 8:00 a.m., a nursing assistant had notified her R2 was not right. LPN-B went to R2's room, he was lying in bed in the fetal position facing towards the wall. LPN-B indicated she was unable to get R2 to open his eyes and notified RN-B and decided to send R2 to the emergency room for further evaluation. During an interview on 8/2/24 at 1:44 p.m., RN-B stated she was called to R2's room on 7/29/24 because R2 was not responding per his normal. R2 was rigid, in a fetal position and pale in color. RN-B stated R2 needed to go to the ED immediately and helped initiate the transfer. During an interview on 8/1/24 at 3:49 p.m., director of nursing (DON) explained after a fall occurs after each fall nursing staff were to implement immediate interventions to prevent another fall. The IDT would then meet the following morning (Monday through Friday) to discuss the fall, try to determine what the cause was, and what appropriate interventions should be in place including the immediate intervention that had been immediately implemented. DON indicated R2's falls that happened after 7/11/24 happened because his care plan for supervision was not followed; All these falls took place in R2 ' s room and were unwitnessed. DON stated she had been made aware of R2's fall that occurred on 7/27/24 when she arrived to work on 7/29/24 and R2 was being transferred to the ED. During an interview on 8/6/24 at 1:55 p.m., medical director (MD)-A, stated the R2 had a history of drug abuse, seemed forgetful, and did not always listen to staff. R2 had numerous falls while at the facility. MD-A could not say for sure when the brain bleed happened. R2 had a head CT on 7/3/24 and 7/10/24 that did not show a brain bleed but the head CT on 7/29/24 did. R3 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3's admission Falls Tool dated 6/11/24, indicated R3 was at low risk for falls. R3 had no falls in the past 12 months, was taking medications that could cause falls and had mild cognitive impairment. Risk factors included cognitive status, reduced insight, and impulsiveness; environmental risk factors of difficulty with orientation and was a new admission. There was nothing checked under the action plan. R3's admission MDS date 6/12/24, indicated R3 to have severely impaired cognition with diagnoses of atrial fibrillation, congestive heart failure, arthritis, osteoporosis, and Parkinson's disease. R3 was independent with transfers, walking and ADL's and used a walker for mobility. R3 had no history of falls. R3's ADL care plan dated 6/13/24, indicated R1 needed one staff assist with, gait belt and four wheeled walker (4WW) for ambulation, bed mobility, toilet use and transfers. Fall care plan indicated R3 had an actual fall with no injury with interventions dated 7/16/24, to provide activities that promote exercise and strength building where possible, consult physical therapy (PT) and occupational therapy (OT) for strength and mobility, and educate R3 and family on safe use of assistive devices. R3's progress notes dated 7/15/24 at 9:30 a.m., indicated a fax was sent to the provider to notify of R3's fall. R3's assessment, neuros, and vital signs were at baseline and denied pain. R3 thought it happened due to legs feeling weaker since R3 had worked with therapy. R3's Fall Huddle Worksheet dated 7/15/24 at 7:15 a.m., indicated R3 had an unwitnessed fall in the bathroom, after attempting to self-ambulate and last staff to see resident were NA-J and NA-K with no date and time listed. Did not identify the last time R3 was assisted with ADL's. R3's Incident Report dated 7/15/24 at 7:15 a.m., identified R3's fall information from the progress notes and fall Huddle with additional information of: R3 received an abrasion to left 2nd toe. Care plan and order were updated with providing activities to promote strength building, consult PT and OT for mobility and strength and to educate R3 and family on safe use of assistive devices. R3's record did not identify a completed comprehensive analysis of causal factors and/root cause to determine appropriate interventions to prevent falls or reduce the risk of falls with major injury. R3's Fall Huddle Worksheet dated 7/16/24 at 7:34 a.m., indicated R3 had an unwitnessed fall in his room where he was found on his knees attempting to self-transfer, lost his strength/knees buckled while R3 used his walker. Did not identify the last time R3 was assisted with ADL's. R3's Incident Report dated 7/16/24 at 7:34 a.m., identified R3's fall information from the fall Huddle with the additional information of: R3 was holding onto his walker and had bumped his head on the walker while trying to stand. R3 stated he was trying to get up for breakfast. R3 was complaining of low back pain, was seen the week prior and noted to have compression fracture in low back. No care plan interventions noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3's progress note dated 7/16/24 at 9:38 a.m., indicated IDT reviewed R3's fall from 7/15/24 at 7:45 a.m. and 7/16/24 at 7:34 a.m., R3 was found on the bathroom floor on 7/15/24 and found on floor next to bed on 7/16/24. R3 was attempting to get up to go to breakfast. Will fax provider for a urinalysis related to back/flank pain and increased weakness and confusion. Will also ask for PT/OT orders for strengthening following fall. R3's record did not identify a completed comprehensive analysis of causal factors and/root cause to determine appropriate interventions to prevent falls or reduce the risk of falls with major injury while waiting for laboratory test results with any follow-up treatment and while R3 gained strength from working with PT/OT. R3's progress note dated 7/20/24 at 8:22 a.m., indicated R3 was found on the floor in his room at 4:30 a.m., no injuries noted, see incident in risk management for details. Further noted at 8:33 a.m. a fax was sent to physician for R3's unwitnessed fall with no injury along with uncontrolled back pain and the scheduled Tylenol 1000 milligrams (mg) was ineffective. Staff requested stronger pain medication. R3's Fall Huddle Worksheet dated 7/20/24 at 4:30 a.m., indicated R3 had an unwitnessed fall in his room while R3 was attempting to self-ambulate, lost his balance while wearing slipper socks and using his walker. Last time staff saw R3 was 30 minutes prior to fall, when staff saw R3 in recliner. Did not identify the last time R3 was assisted with ADL's. R3's Incident report dated 7/20/24 at 4:30 a.m., indicated R3 was found on the floor in front of the recliner when the nurse arrived R3 was lying on floor holding his head up. R3's record did not identify a completed comprehensive analysis of causal factors and/root cause to determine appropriate interventions to prevent falls or reduce the risk of falls with major injury. R3's progress note dated 7/30/24 at 4:31 p.m., indicated nurse summoned to R3's room as laundry staff observed R3 seated on the floor in front of his recliner with one foot at his side and one foot on the chair. R3 then ambulated with FWW in his room to his wheelchair and was brought to lounge area with vital signs taken frequently. R3's Fall Huddle Worksheet dated 7/30/24 at 4:00 p.m., indicated R3 had an unwitnessed fall while reaching to move trash bucket out of the way and lost his balance, was wearing shoes and using his walker at time of the incident. Last staff to see resident, resident ambulating per self with 4WW throughout facility, all staff allowing this to happen. No name of staff or date and time listed for last seen by. Does not identify the last time R3 was assisted with ADL's. R3's Incident Report dated 7/30/24 at 4:00 p.m., indicated R3 was found sitting on floor in front of the recliner by the laundry. R3's feet were out in front of him and one at the side out of the chair. On 7/30/24, order received to discontinue the Oxycodone per R3's request and an order received for lidocaine external patch 4%, apply one patch a day for up to 12 hours. R3's medical record lacked root cause analysis and implementation of prevention interventions for R3's numerous falls to mitigate the risk for future falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on 8/1/24 at 12:57 p.m., R3 was self-propelling his wheelchair from the dining room. At 4:00 p.m., R3 was seated in his wheelchair in the common area. During an interview on 8/1/24 at 1:52 p.m., TMA-A stated R3 had a change in status over the past month, felt R3's memory was getting worse as R3 would not remember to ask for assistance or use his call light. TMA-A further stated that R3 was having more pain and nursing was working with the provider on this. During an interview on 8/1/24 at 2:25 p.m., NA-E stated R3 was not independent, used a wheelchair and staff were to leave his door open to watch in case he self-transferred. During an interview on 8/1/24 at 2:33 p.m., NA-B stated R3 was confused and attempted to self-transfer. R3 needed 1 staff assist with transfers with the use of a gait belt. During an interview on 8/1/24 at 3:20 p.m., NA-Z stated R3 was independent when he arrived about a month ago but has gone downhill lately. NA-Z further stated R3 had increased confusion, does not like to stay in his wheelchair, forgets to ask for assistance and gets frustrated quickly when staff remind him to ask for assistance or use his call light. During an interview on 8/2/24 at 8:15 a.m., NA-S stated R3 was admitted to the facility independent and continent, but after some falls, he was to use wheelchair and was needing more care from staff with his ADLs including going to the bathroom and changing his brief or pull up. R2 would let staff know when he had to go to the bathroom or the staff would catch him self transferring. During an interview on 8/1/24 at 3:49 p.m., DON indicated after reviewing R3's falls, a comprehensive analysis of the falls had not been completed for appropriate interventions. DON indicated the facility had identified gaps in the falls program with causal analysis to which the facility implemented a quality assurance performance improvement (QAPI) project in June 2024; the cause analysis was a work in progress. DON stated she expected staff to follow the resident's care plans and the fall policy and procedures. Review of facility's policy entitled Fall Resource Packet - Rehab/Skilled, dated 5/7/24, indicated the following: - refer to Fall Prevention and Management policy, INTERACT Fall- Care Path, AMDA clinical practice guideline (CPGs) and AMDA Know-it-All card for additional information regarding actions to take post-fall. - Staff were to complete the following PCC: -Falls Tool UDA -Change in Condition (if applicable) -neuro Check UDA (triggered from risk management incident types: slipped or fell , found on the floor, fall involving mechanical lift) -pain evaluation (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-vital signs -risk management module- new incident, for the type of fall. -Check the care plan to determine if the cause of the fall is addressed (to avoid additional falls from the same cause). Consider setting a short-term goal to assist with monitoring the fall interventions closely to determine effectiveness; if not effe [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355 Based on interview and record review the facility failed to complete a comprehensive bladder assessment and develop an individualized toileting program to restore, maintain, or prevent a decline in continence for 2 of 2 residents; R3 who had a change in mobility and R2 who had a documented decline in continence. Findings include: R3's admission Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment with diagnoses of cancer, heart failure, arthritis, and Parkinson's disease. R3 had no impairment of range of motion and used a walker. R3 was independent with his activities of daily living (ADLs) except needed supervision with eating and oral hygiene. R3 had no history of falls. R3 was always continent of bowel and bladder and did not have a toileting program. R3's bowel and bladder assessment from the Nursing Admit Re-Admit data collection ([NAME]) tool, dated 6/6/24, indicated R3 was continent of bowel and bladder. No other bowel and bladder information was included on the assessment. R3's care plan (current at the time of the suvey) did not identify bladder/bowel focus that identified R3's toileting needs. The ADL care plan dated 7/23/24 identified the following: -ambulation with assist of one, gait belt and four wheeled walker (4WW), dated 7/23/24, -bed mobility with assist of one, gait belt and 4WW, date 7/23/24, -toilet use with assist of one, gait belt and 4WW, dated 7/23/24. During an interview on 8/2/24 at 8:15 a.m., nursing assistant (NA)-S stated R3 was admitted to the faciity independent and continent, but after some falls, he was to use wheelchair and was needing more care from staff with his ADLs including going to the bathroom and changing his brief or pull up. NA-S indicated R3 did not have a toileting program, R3 would let staff know when he had to go to the bathroom or the staff would catch him self- transferring to the bathroom. During an interview on 8/6/24 at 12:46 p.m., NA-D indicated R3 needed assistance to transfer, had confusion, would attempt to self-transfer, and did not have a toileting schedule. During an interview on 8/6/24 at 3:07 p.m., NA-P stated she would take R3 to the bathroom at least before and after supper. R3 did not have a toileting schedule. R2's bowel and bladder assessment from the [NAME] tool, dated 7/9/24, indicated R2 was continent of bowel and bladder, used a urinal, had urgency, and needed assistance with clothing management. The assessment did not include any other information. R2's care plan did not include identify a toileting program. The care plan included: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R2 required staff assist of one with clothing management, dated 7/9/24. -Staff to keep urinal in reach, check and empty frequently, dated 7/9/24. R2's admission MDS dated [DATE], indicated intact cognition with diagnoses of hip fracture, other fracture, osteoporosis, and dementia. R2 did not have a toileting program and was frequently incontinent of bowel and bladder. R2 had impairment on one upper and lower extremity range of motion (ROM). R2 used a walker and wheelchair. R2 required partial to substantial assistant for all his activities of daily living (ADLs). R2 required moderate assist for transfers and did not walk more than 10 feet. R2's record did not include a comprehensive assessment in R2's change in level of continence nor physician notification of R2's bladder control changes. Further the care plan did not address individualized interventions to restore, maintain, or prevent worsening. During an interview on 8/2/24 at 8:15 a.m., NA-S indicated R2 would use urinal if he remembered but wore brief and staff were responsible for changing. NA-S further stated R2 was not on scheduled toileting or check and change program. During an interview on 8/6/24 at 12:46 p.m., NA-D stated R2 used a urinal and wore a brief. R2 was frequently incontinent and needed staff assist with managing his brief. NA-D was not aware if R2 was on a scheduled toileting or check and change program. During an interview on 8/2/24, DON stated the bowel and bladder assessment was completed on admission. If the resident was continent it would not trigger a care plan focus for bowel and bladder. DON stated it was her expectation staff followed the facility's bowel and bladder evaluation policy. Review of facility's policy entitled Bowel and Bladder: Evaluation. Assessment, Toileting Programs-Rehab/Skilled, dated 5/21/24, did not identify timing of assessments outside completion of Care Area Assessment and/or protocals for when residents had a change in condition/function. The policy included the following: -Based on the resident's comprehensive assessment, the location will ensure that each resident with bowel and bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder functioning as possible. -Check and change every two hours would not be considered a scheduled toileting program on the MDS. -The type of incontinence should be identified based on information obtained and evaluated using the Bladder Evaluation UDS, and the Care Area Assessment (CAA). -Care plan interventions should be individualized based on the CAA and modified as appropriate based on an assessment/evaluation of the resident's response to the interventions and success with attaining/maintaining bladder continence. -individualized program will be communicated to staff members via PCC/POC-Kardex and the 24-hour Report and Shift Report in PCC.