STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

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

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess, monitor and implement interventions for 1 of 1 resident (R1), who experienced a fall with injury. R1 sustained actual harm, a subdural hematoma and pelvic fracture resulting in a discomfort and a decline in mobility. Findings include: R1's admission record indicated the resident was admitted to the facility on [DATE]. R1's [DIAGNOSES REDACTED]. Review of R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R1 as having a brief interview for mental status (BIMS) score of 7 (indicating R1 had moderately impaired cognition). The MDS indicated R1 was independent with bed mobility and transfers with set up assistance only. The MDS also indicated R1 was independent with ambulating in room with set up assistance and ambulated in the corridor with staff supervision, and a walker for ambulation. Further, the MDS indicated R1 was independent with toileting, and exhibited no impairment in range of motion (ROM) to the upper or lower extremities. During observation on 6/23/20, at 10:30 a.m. R1 was resting in bed. R1 was observed to be repositioned by staff while in bed. R1 offered no complaints during the care, but stated she wanted to go home. R1's left eyebrow was slightly swollen and bluish in color. Review of an incident report dated 6/17/20, at 5:00 a.m. indicated [REDACTED]. The report indicated R1 alerted staff she had fallen by yelling out loudly. R1 was found laying on her right side on the floor. The report indicated R1 stated she was attempting to go to the bathroom when she fell . R1 was incontinent and obtained a laceration to the outer left eyebrow that was swollen and bleeding. The laceration was identified a s measuring 3.0 centimeters (cm). Steri-strips and an ice pack were applied to control the bleeding, R1 complained of pain when touched. R1 had previously been independent with ambulating and toileting. The report further indicated R1 had no other injuries or complaints when assessed. Neurological checks were initiated. Review of R1's medical record included neurological checks on 6/17/20, at 5:30 a.m., 5:37 a.m., 6:05 a.m. and 9:13 a.m. 5:36 a.m. vital signs (VS) and neurological assessment (neuro) = within normal limits (WNL). Pain = 0 (pain scale of 1-10 meaning 1 mild and 10 severe). Eyebrow laceration oozing blood. Ice Pack applied. 5:37 a.m. VS and NA = WNL. Pain = 1 6:05 a.m. VS and NA= WNL. Pain=0. Slight oozing of blood from eyebrow laceration. 9:13 a.m. VS and NA = right leg and left leg weak. Pain =1. No action was taken when R1 was identified with weakness in the lower extremities with pain. The progress note indicated R1 was having difficulty standing and required extensive assistance to the toilet. A mechanical lift was required. The note also indicated R1's left eyebrow laceration continued to bleed and R1 was refusing to eat. There were no further VS or neuro checks completed after 9:13 a.m. when R1 exhibited signs of a change in condition. The medical record indicated R1 was given scheduled Tylenol at 7:39 a.m. There was no offer of pain medication at any other time. R1's post fall progress notes were reviewed for 6/17/20: At 6:04 a.m. an entry indicated R1 was resting in bed, denied complaints of pain and an ice pack was applied to the left side of the forehead. R1's laceration on the forehead was described in the notes as having 10 cm of blood from the area. At 7:39 a.m. an entry indicated R1 required assistance of a pivot transfer to wheelchair when assisted to the bathroom. The note further indicated R1 had no complaints. At 9:20 a.m. an entry indicated a fax was sent to the provider indicating R1 had a fall and obtained a 3.0 cm laceration on the left outer eyebrow. Steri-strips and an ice pack were applied with no other injuries noted. (There was no return fax from the provider verifying notification). At 9:24 a.m. an entry indicated R1 was attempting to get out of bed but required extensive assistance of staff to the toilet. R1's laceration on the left eyebrow was described as bleeding, and the note indicated a new pressure dressing was applied to control the bleeding. R1 refused breakfast when offered. The note further indicated R1 had trouble standing during assistance to the toilet and a standing lift was needed. At 10:36 a.m. an entry indicated R1 was scratching at the laceration on her left eyebrow and causing it to bleed more. At 11:53 a.m. an entry indicated R1's eyebrow laceration continued to bleed and new steri-strips and pressure dressings were applied. At 11:55 a.m. an entry note indicated there was increased bleeding from R1's laceration on the left eyebrow and another pressure dressing was applied due to saturation of blood. The note further indicated R1 had blood under her fingernails and may have been scratching at the laceration. At 12:20 p.m. an entry indicated R1 refused to eat dinner when offered. At 12:42 p.m. an entry indicated the laceration over R1's left eye continued to ooze blood and the eye was swollen shut. The facility's physician assistant (PA) was notified and indicated she would provide a house visit to assess the resident. At 1:03 p.m. an entry indicated the facility PA assessed R1 and ordered a transfer to the emergency department (ED) by ambulance for further evaluation of the head wound and left hip pain. At 2:24 p.m. an entry indicated a nurse from the ED informed the facility R1 was being transferred to the Mayo hospital in Mankato MN for further treatment, due R1 having a subdural hematoma and pelvic fracture. A summary of the progress notes indicated R1 had a change in condition at 9:24 a.m. when R1 had difficulty standing and required extensive assistance of staff to the toilet, requiring a mechanical lift. R1 had previously been independent with mobility. R1's laceration on the left eyebrow continued to bleed requiring continued pressure and the resident was refusing to eat. The medical record did not include a thorough evaluation/assessment of R1's decline in condition or weakness, nor did it include a pain assessment to include thorough monitoring of R1's left hip pain or control. Review of the PA visit progress note dated 6/17/20, at 1:00 p.m. indicated the PA was notified by facility staff R1 had fallen and had become more lethargic since the fall. The PA stated she was told by staff R1 was previously independent with mobility, but since the fall had been in bed and now required total assistance. The PA indicated she was informed R1 refused to eat or drink all day other than a sip of water taken with her medications at 9:00 a.m. on 6/17/20. The PA stated facility staff had further informed her they'd been unable to control the bleeding from R1s left eyebrow laceration after the fall, even when applying pressure. The PA also stated she was informed R1 had complained of nausea right after the fall, and stated the staff had reported they'd changed the pressure dressing to the resident's left eyebrow laceration 3-4 times throughout the day and could not obtain homeostasis. The PA indicated R1 had also reported left hip pain. Review of the 6/17/20 physical exam results by the PA, indicated R1 was identified to be lethargic and moaning in pain. R1 responded but did not open her eyes during the exam. The laceration on R1's left eyebrow was actively bleeding and swollen with an obvious hematoma formation. Finally the PA's note indicated R1 was to be transferred by ambulance to the ED for further evaluation. Review of an ED progress note dated 6/17/20, at 2:20 p.m. indicated R1 was examined after arrival to the ED. R1 continued to have bleeding from the facial laceration as well as moderate complaints of left hip pain. A computed tomography (CT) scan of the head was ordered with findings of an acute cerebral convexity subdural hematoma with periorbital soft tissue swelling. A CT scan of the pelvis was ordered with findings of an acute minimally displaced [MEDICAL CONDITION] pubic body. The ED progress note indicated R1 would be transferred to the Mayo hospital in Mankato MN for further evaluation and treatment. Review of a Mayo hospital discharge summary note dated 6/19/20, indicated R1's fractured pelvis and subdural hematoma were evaluated and it had been determined R1 was a high risk surgical candidate and therefore surgery was not recommended. R1's family chose comfort care measures only and R1 was discharged back to the

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

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) nursing home facility with hospice care services During an interview on 6/23/20 at 11:45 a.m., case manager (CM)-A stated she provided care for R1 after the fall. CM-A stated she felt R1 was stable until around 11:30 a.m., when R1's eyebrow laceration continued to bleed. CM-A further stated she felt R1's condition had not changed enough to warrant notification of the provider until that time. CM-A stated, Although (R1's) laceration on the eyebrow continued to bleed, (R1's) neuro and VS were within normal limits even though a change in (R1's) mobility had been identified by a nursing assistant at 9:13 a.m CM-A confirmed R1 had been independent with mobility before the fall and at 9:13 a.m. on 6/17/20, R1 could not bear weight requiring a mechanical lift for transfers. CM-A also confirmed R1 had periods of left hip pain, but felt it was minimal. CM-A stated she'd only called the physician assistant (PA) because she thought R1's laceration needed stitches to stop further bleeding. During interview on 6/23/20 at 11:30 a.m., nursing assistant (NA)-A and NA-B stated they had both provided care for R1 on 6/17/20, after the fall. NA-A and NA-B stated R1 started to complain of left hip pain around 8:30 a.m. when repositioned in her bed. NA-A and NA-B said R1 was weak and required total assistance with all activities of daily living (ADL's) that included mobility. NA-A and NA-B confirmed R1 had been independent with mobility prior to the fall. NA-A and NA-B further indicated R1's laceration on the left eyebrow continued to swell and bleed through several pressure dressings throughout the morning. NA-A and NA-B further added R1 had been sleepier, refused to eat and stayed in bed all morning. NA-A and NA-B both stated they reported R1's changes in condition to CM-A when identified. According to interview with registered nurse (RN)-A on 6/23/20 at 2:45 p.m., RN-A confirmed she'd provided care for R1 at the time of the fall. RN-A stated she assessed R1 and did not identify any injuries other than a 3.0 cm laceration above the left eye, that was noted to be bleeding slightly. RN-A stated R1 denied complaints of pain when RN-A evaluated R1's extremities, adding that R1 was alert and she didn't note any change in cognition. RN-A further indicated a mechanical lift was used to transfer R1 back into bed per protocol. RN-A stated she was unsure whether R1 could bear any weight at that time because they did not attempt to have R1 bear any weight. When interviewed on 6/23/20 at 3:00 p.m., the facility's physician assistant (PA) confirmed the above documented dictated notes from the visit she made for R1 on 6/17/20. The PA stated when she examined R1 there was blood all over the resident's face, neck and upper body from the laceration on the left eyebrow, and the left eye was swollen shut. The PA stated there was a lot of bleeding from the laceration making it difficult to see the depth of the wound. The PA further indicated R1 was moaning in pain during attempts to sit her up in bed. The PA stated she assessed R1's extremities and the resident complained of left hip pain with range of motion (ROM). The PA further reported staff had informed her R1 had been more lethargic and weak, and the dressing on the eyebrow had required several dressing changes over the prior hour, due to increased bleeding and saturation of the dressings. The PA stated she should have been notified sooner when the resident's condition was noted to have changed. Changes that included not bearing weight and requiring a mechanical lift for transfers, pain in the left hip area, and the uncontrolled bleeding from the laceration on the left eyebrow were significant, and the PA stated earlier treatment could have prevented or decreased discomfort for R1. The director of nursing (DON) and administrator were interviewed on 6/24/20 at 1:00 p.m., and reviewed the record with the surveyor. They confirmed R1's condition had declined after the fall. The DON stated staff had not implemented the facility's policy/guidelines for monitoring neurological checks/assessments, nor had the staff completed the facility's change in condition checklist, or provide interventions to provide comfort for R1. The DON and administrator verified the medical provider should have been contacted to provide direction related to changes observed for the resident. The facility's procedure Neurological Evaluation revised 1/20, indicated staff were to complete a neurological evaluation when a resident had an unwitnessed fall, or following an event that results in a known or suspected head injury. The procedure included: Initiate and document a baseline neurological evaluation after the incident, notify the provider of the event and findings of the evaluation, obtain orders for subsequent neurological evaluations or other medical care, after the completion of the initial neurological evaluation with vital signs, continue with evaluations every 30 minutes for 4 times, then every 8 hours for 3 days or as directed by the provider. The policy further included: Evaluate and compare subsequent neurological evaluations to the initial baseline and previous evaluations and notify the provider of any neurological findings, which are a change from the baseline or previous evaluations. The facility's procedure for Change in Condition Evaluation revised 5/16/20, directed staff to complete a change in condition checklist to improve communication between nurses and the provider when nursing was monitoring a change in condition, and to enhance the nursing evaluation and documentation of a resident who has a change in condition. The procedure indicated the evaluation would provide a standard format to collect pertinent clinical data prior to contacting the provider when there was a change in condition.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing preventive measures to prevent the spread of COVID-19. This had the potential to affect all 61 residents who resided at the facility. Finding include: During an observation on 6/24/20, at 11:00 a.m. licensed practical nurse (LPN)-A was in the nurses' station without a facemask, preparing to give a resident medication. The resident was approximately one to two feet away from LPN-A and was also unmasked. LPN-A stated when he is at the nurses' station he is not required to wear a facemask, and further stated he got too hot wearing the mask. During an observation on 6/24/20, at 11:15 a.m. activity assistant (AA)-A was in the lounge sitting within a foot of a resident reading a book. AA-A was not wearing eye protection. AA-A stated she was not required to wear eye protection, except when feeding a resident. During an interview on 6/24/20, at 11:30 a.m. the activity department director (AD)-B confirmed activity staff were only required to wear eye protection when feeding a resident. During an observation and interview on 6/24/20, at 11:40 a.m. registered nurses (RN)-B and (RN)-C were in the nurses' station, not wearing facemasks or eye protection. The nurses' station was open to the unit, having only two walls and one counter-height peninsula. During the observation, residents self-propelled or walked within six feet of these staff. RN-B and RN-C stated they were not required to wear a facemask or eye protection at the nurses' station. During an observation and interview on 6/24/20, at 11:45 a.m. R1 was seated in the north dining room with other residents, eating lunch. R1 was on day five of a 14 day quarantine after returning from the hospital on [DATE]. Registered nurse (RN)-A stated that R1 was considered to be in the gray zone per the facility cohort plan. RN-A stated R1 was not confined to her room for the 14 day quarantine period and while staff were required to wear a facemask, eye protection, and gloves when caring for R1, a gown was not required. During an observation on 6/24/20, at 12:05 p.m., residents were observed self-propelling in hallways without masks. During an interview on 6/24/20, at 12:10 p.m. in her room, R4 stated we're not required to wear a mask here unless we leave for an appointment. During an interview and observation on 6/24/20, at 12:20 p.m. the director of nursing (DON) stated residents wear a mask when they leave their room if they want to. The DON further stated residents are asked at the time of admission if they want to wear a mask. The DON was observed wearing her personal eye glasses with detachable eye shields on each side, for eye protection. During an observation and interview on 6/24/20, at 12:45 p.m. RN-A was sitting at the nurses' station with her mask off, interacting with a staff person who was one to two feet away. RN-A stated staff were not required to wear facemasks while at the nurses' station. On 6/24/20 at 12:50 p.m., R1 was observed resting in her room on the north end of the facility. There were no signs outside her door indicating she was in quarantine and no cart outside her room for personal protective equipment (PPE). During an observation on 6/24/20, at 12:55 p.m. nursing assistant (NA)-A was feeding two residents at a dining table with her facemask below her nose. NA-A stated it was hard to breathe with her mask on, so she put it below her nose at times. During an interview on 6/24/29, at 1:00 p.m. the administrator stated R1 was not quarantined, and stated the facility was using guidance from their corporation to determine which residents required quarantine. The administrator said R1 did not meet quarantine criteria therefore staff were not required to wear gown and gloves when entering R1's room to provide care. During an interview on 6/24/20, at 1:15 p.m. DON stated she thought residents could be asked if they wanted to wear a mask. The DON stated residents are offered masks weekly, but have the option to refuse. Further, the DON stated it was acceptable practice for staff to remove their eye protection and/or mask when at the nurses' station when not providing direct care to a resident. The DON stated staff were required to wear a facemask and eye protection when feeding a resident. Facility policy titled Infection Prevention, revised date 6/16/20, indicated: 1. Purpose was to provide guidance to healthcare personnel working in healthcare settings who have the potential for exposure to patients presenting with an emerging respiratory threat including coronavirus. 2. To prevent the transmission from person to person of respiratory pathogens. 3. To prepare for emerging threat of Covid19. 4. To provide guidance for screening of suspected Covid-19 cases. 5. Facemask's will be worn by all employees working in a facility where any clinical activity or patient care is being delivered, or while providing services in a patient's home. 6. Healthcare workers, when in close contact or providing continuous care for 15 minutes or more, will wear eye protection

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) unless the patient or resident is wearing a cloth or surgical mask. 7. Upon identification of any resident with suspected or positive Covid19, a droplet precautions sign will be posted on the outside of the resident's room. The resident will be isolated in their room with the door closed. Staff will wear eye protection that covers both the front and sides of the face. 8. Appendix C: PPE Conservation - Reuse: all caregivers providing direct patient care will receive one surgical facemask per day/shift and a faceshield. Those not providing direct care, but who work in any facility where any clinical activity or patient care is being delivered, or interactions occur, will receive one surgical facemask per five days/shifts and a faceshield. All health care workers must wear eye protection when in close contact/providing continuous care for 15 minutes if the patient/resident is not wearing a cloth mask or surgical mask. Facility policy titled Cohorting Plan for Skilled Nursing Facilities (SNFs), updated 6/4/20, indicated: 1. Facilities should plan to identify red, yellow and green zones where the residents can be cohorted based on their symptoms and exposure risks to Covid19. Facilities are also recommended to establish a transitional zone (gray zone) for asymptomatic patients who are being transferred from other healthcare facility. The residents will be placed in different zones based on meeting certain criteria. 2. All nursing homes should consider establishing a transitional zone for new admissions, returning residents from the hospital or those who are traveling in and out of the nursing home. Transitional zones/units are established to quarantine those residents who are at somewhat higher risk of getting exposed to Covid19 but have no know exposure to Covid19. 3. Residents are kept in this zone for 14 days. If he/she remains asymptomatic (no new symptoms, no fever) at the end of the 14 days without the use of antipyretics (fever reducing medication), he/she will be moved to the green zone. 4. Light red zone criteria: all residents who are symptomatic and suspected to have Covid19 even if the test results are not back. 5. Dark red zone criteria: all residents that have tested positive for Covid19. 6. Yellow (quarantine zone) criteria: all asymptomatic residents who may have been exposed to Covid19. 7. Green zone (covid-free) criteria: all asymptomatic residents who are not considered to be exposed to Covid19. 8. Gray zone (transitional zone) criteria: all asymptomatic residents who are being admitted /readmitted to the nursing home from an outside facility and have no known exposure to Covid19. a. Healthcare workers should wear PPE as follows: surgical mask, eye protection, and gloves as needed when taking care of these patients. b. Residents are kept in this zone for 14 days. If he/she remains asymptomatic (no new symptoms, no fever) at the end of the 14 days without the use of antipyretics, he/she will be moved to the green zone.