Electronically Submitted
October 22, 2021

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: October 8, 2021

Dear Administrator:

On October 8, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On October 8, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 6, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 6, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 6, 2021,(42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 8, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - Specialty Care Community is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 8, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division

Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 8, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services,

Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services

Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Bike-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY ROBBINSDALE, MN 55422**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

On 10/6/21, through 10/8/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.

The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 10/3/21, at 3:40 p.m. when R1 eloped from the facility, and was found several blocks away from the facility. The director of nursing (DON) was notified of the IJ on 10/7/21. The IJ was removed on 10/8/21, but non-compliance remained at a lower scope and severity of a D, isolated, no actual harm, with potential for more than minimal harm that is not an IJ.

The above findings constituted substandard quality of care, and an extended survey was conducted on 10/7/21.

At the time of the abbreviated survey, an onsite investigation was completed and the following complaint was found to be SUBSTANTIATED: H5279104C (MN77302), with a deficiency cited at F689.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/25/2021

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

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F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess elopement risk, implement interventions, and prevent an elopement for 1 of 3 residents (R1) reviewed for elopement who successfully eloped from the facility. This deficient practice resulted in immediate jeopardy (IJ) to resident health and safety. R1 eloped from the facility on 10/3/21, at 3:40 p.m. and was found by staff on the street near the facility. In addition, the facility failed to complete elopement assessments, and identify and implement interventions for 2 of 3 residents (R2, R3) who had documented exit seeking behavior, wandering, and/or elopement attempts. The IJ began on 10/3/21, when R1 successfully eloped from the facility through an alarmed door after he removed his RoamAlert bracelet (an electronic device used to monitor and alert a resident's location) and went off the facility grounds, and was found on the street near the facility. The facility was initially unaware R1 was gone from the building. R1 was located outside	F 689	R1 was reassessed on 10/5/2021 and 10/7/2021 for elopement risk and care plan was updated and interventions initiated for a roam alert bracelet and will be checked for placement every shift. Room searched on 10/7/2021 to ensure no sharp objects are present that could be used to remove the roam alert. Care plan updated to conduct room search on AM and PM shifts daily. Resident remains on locked unit. Resident will be seated further away from exit door during meals and redirected if seated next to the exit doors. Education was provided to family member who let the resident out of the locked unit on 10/3/2021. All staff caring for R1 were re-educated prior to the start of their shift on elopement prevention and R1's care planned interventions. All residents at risk for elopement were reviewed and reassessed. Care plans were reviewed and updated as necessary	10/27/21

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F 689	Continued From page 2 the building by staff, who followed R1 until the police brought R1 back to the facility. The director of nursing (DON) was notified of the IJ on On 10/7/21, at 9:28 a.m. The IJ was removed on 10/8/21, at 2:00 p.m. but non-compliance remained at a lower scope and severity level of D, isolated, no actual harm, with potential for more than minimal harm. Findings include: R1's Face Sheet printed 10/6/21, indicated R1's diagnoses included dementia with behavioral disturbance, psychoactive substance abuse, and depressive episodes. R1's significant change Minimum Data Set (MDS) dated 8/5/21, indicated R1 had a severe cognitive impairment and displayed wandering behavior 1 to 3 days during the review period. The MDS indicated R1's wandering did not put him at significant risk of getting to a potentially dangerous place (stairs, outside of the facility). R1 required supervision for locomotion on the unit, and did not perform locomotion off the unit during the assessment period. R1's Care Area Assessment (CAA) for dementia dated 8/18/21, indicated R1 had displayed wandering behavior one day during the review period. R1 displayed confusion, forgetfulness, and impulsivity. R1's CAA for behaviors dated 8/18/21, indicated R1's behavior status, care rejection, or wandering had worsened since the last assessment. R1 had a RoamAlert in place which may have exacerbated his behaviors. The objective was to minimize risks for R1, and help him to remain	F 689	to ensure interventions are in place to prevent elopement. Facility Policy and Procedure for Elopement was reviewed and it was determined to be appropriate. Education was initiated to all staff on 10/5/2021 regarding the facility's policy and procedures for elopement, identification and reporting, and implementing interventions on the care plan. All staff were provided with re-education on the policy and procedure for elopement with a posttest to verify understanding. Education implemented into general orientation on 10/15/21. Routine elopement drills were implemented on 10/7/21 weekly x4 and then monthly. A new process was initiated on 10/7/21 for visitors to the secured unit. All visitors receive written education regarding safety measures to prevent resident elopements with signature required for acknowledgement. On 10/6/2021 the audit process began for elopement prevention. The Associate Quality Strategist and/or designee is responsible to ensure compliance through routine audits weekly x4. These audits will include ensuring new residents have an elopement assessment, a record review to identify new exit seeking residents and monitor effectiveness of interventions for residents that are already identified as elopement risks. Audit results will be	

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F 689	Continued From page 3 safe on the unit. R1's care plan dated 5/11/21, indicated R1 had impaired cognitive function related to his dementia diagnosis. The care plan indicated R1 was impulsive, with lack of insight into safety. The care plan also indicated R1 had a potential for elopement. The care plan updated 8/4/21, indicated R1 had a history of actual elopement and potential for future elopement. Interventions to keep R1 safe included R1 being on the secure unit, a RoamAlert bracelet on R1's left wrist per preference (which R1 had a history of cutting off), and ensuring that exit door alarms were in working order. R1's Behavior Monitoring Task was reviewed for 7/1/21, through 10/6/21 and R1 displayed wandering behaviors on 16 days, and exit seeking behavior on 4 days. On 6/15/21, at 7:31 a.m. a progress note indicated R1 was moved to the secured (locked) unit. On 7/28/21, a physician progress note indicated R1 displayed "some anxiety and heightened concern regarding simply being in a facility and wanting to leave." R1 displayed a flat, intense affect and stare, and repeated frequently he wanted to leave the facility. On 7/31/21, at 11:58 p.m. a progress note indicated R1 left the unit when he followed a visitor out. R1 was found in the elevator. R1 was redirected back to the unit. R1 stated, "I am going home. I am going home." The note indicated the facility would continue to monitor R1 closely.	F 689	taken to monthly QAPI committee for further recommendations.	

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F 689	Continued From page 4	F 689		

On 8/1/21, at 2:44 p.m. a progress note indicated R1 tried to force his way off the unit every time someone came in or went out. The note further indicated R1 did get off the unit one time, and was redirected back to the unit without further incident.

On 8/1/21, R1's Physician Orders indicated the following order was placed: Wander Guard (device similar to a RoamAlert) to unit for patient safety, attempts to elope from unit. Check every shift for placement and function.

On 8/16/21, a physician progress note indicated definite concerns regarding insight, impulsivity, and consequential thinking. Optimal to consider a surrogate decision maker, guardian/conservator.

R1's Elopement Assessment dated 8/23/21, indicated R1 was at risk for elopement due to a history of leaving the building and wandering, anger regarding facility placement, elopement attempts in the past, packed belongings, and verbalized statements about leaving. The assessment further indicated staff should check RoamAlert placement and functionality every shift. Elopement education was not provided to R1 or a representative, as R1 had refused education.

On 8/30/21, at 8:54 a.m. a progress note indicated R1 had cognitive loss and required a secure unit per physician order. R1 had lack of insight into deficits and felt he could be in his apartment. In the last 90 days R1 had displayed 12 episodes of pacing, four episodes of exit seeking and 12 episodes of wandering.

On 9/13/21, at 11:18 a.m. a progress note

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F 689	Continued From page 5	F 689		

indicated there was a discussion with the nurse practitioner (NP)-A that R1 had been cutting off the RoamAlert bracelet, and would not keep it on. A new order was received to discontinue the RoamAlert.

On 10/3/21, at 4:56 p.m. a progress note indicated at 3:40 p.m. R1 exited the locked unit when a family member entered. The family member did not alert staff R1 had left until about five minutes later. Both registered nurse (RN)-A and RN-B searched the facility and could not find R1. Trained medication assistant (TMA)-A searched the street and found R1 walking on Broadway Avenue and followed R1. R1 became combative, so TMA-A followed R1 to McDonald's then called RN-A and RN-B, who called the police. TMA-A called the facility again when she and R1 were behind Broadway pizza. The facility updated the police on R1's location, and RN-A and RN-B drove to Broadway pizza at 4:40 p.m. and found R1 and TMA-A together. R1 had a pizza in his hand. The police then arrived at which time RN-A, RN-B, and TMA-A drove back to the facility, and a police officer dropped R1 at the facility entrance. R1 was not handed off to the staff, and again left the building towards Broadway. RN-A followed him. RN-B ran to assist, held R1's shirt, took the pizza, and calmly told R1 to follow her back to the facility. RN-A had already called the police who came when they were almost at the facility and walked with RN-A and R1 back to the floor. R1 was assisted to his room, was given his pizza and a coke. The note indicated they would continue to monitor R1's safety.

On 10/4/21, Physician Orders indicated the following: Ok to attempt RoamAlert again. Has

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history of cutting off. Check placement and function every shift.

On 10/4/21, at 12:04 p.m. a progress note indicated RN-D and the social worker discussed R1's elopement from yesterday. R1 was educated on the risk for harm when leaving and the need for a RoamAlert bracelet to ensure his safety. R1 had a history of cutting off the bracelet. RN-D spoke with NP-A regarding trying another attempt of the RoamAlert. R1 agreed to RoamAlert bracelet and promised not to remove it.

R1's Elopement Assessment dated 10/5/21, indicated R1 was at risk for elopement due to a history of leaving the building, anger regarding facility placement, elopement attempts in the past, elopement successes in the past, packing belongings, removing RoamAlert device, and verbalizing statements about leaving. Elopement education was provided to both to R1 and other resident's family members.

On 10/5/21, at 3:43 p.m. a progress note indicated a room search was conducted for sharp objects that could be used to cut off the roam alert. Scissors were removed from R1's room. R1's RoamAlert remained on, and staff assisted R1 to unpack belongings from suitcases and organize his room.

On 10/6/21, at 10:47 a.m. R1 was observed to exit his room and walk past the nursing station toward the dining area. Nursing assistant (NA)-A asked R1 what he needed, and redirected him back towards his room. At 10:56 a.m. a large nail clipper was observed on R1's nightstand.

On 10/7/21, at 12:52 p.m. R1 was observed to

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	245279	A. BUILDING _____ B. WING _____	C 10/08/2021

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exit his room, entered another resident room, took a remote control, and returned to his own room and closed the door. At 12:54 p.m. four disposable shaving razors were observed on R1's dresser.

On 10/6/21, at 10:35 a.m. NA-A was interviewed and stated R1 had a RoamAlert bracelet in place a few months ago, but he cut it off and would refuse to have it put back on. NA-A stated she was unaware what R1 used to cut off the bracelet. NA-A stated R1 was an elopement risk according to his care plan, and he needed to be checked on frequently. NA-A stated there were no formal frequent checks in place for R1, and only one NA on this unit for 16 residents. NA-A stated she checked on R1 hourly or every two hours.

On 10/6/21, at 10:56 a.m. R1 was interviewed. R1 stated he had removed his RoamAlert bracelet in the past. R1 stated, "I want to live at home."

On 10/6/21, at 11:05 a.m. RN-C was interviewed. RN-C stated R1 was an elopement risk, and needed to be on the locked unit. RN-C stated R1 was an "opportunist." RN-C stated a RoamAlert bracelet was placed on R1 in August; however, R1 was "real tricky" and he removed the bracelet. RN-C stated R1 would attempt to take a table knife and cut it off, and had a fingernail clipper hidden in his cell phone at one point. RN-C stated staff tried not to allow R1 access to clippers, and they had tried using plastic cutlery with R1, which was not effective. RN-C verified R1's RoamAlert bracelet was discontinued, because he would not keep it on. RN-C stated there was no formal monitoring in place for R1; however, staff tried to "watch him more closely." At 11:13 a.m. RN-C

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entered R1's room and verified the presence of a nail clipper on R1's nightstand. R1 stated, "That should not be here." RN-C stated staff attempted to complete room checks daily for R1, although there were no formal checks in place.

On 10/6/21, at 11:18 a.m. RN-D was interviewed and verified the presence of a nail clipper on R1's nightstand. RN-D stated he completed a room search for R1 yesterday, and the nail clipper was not there. RN-D stated R1 had removed his RoamAlert bracelet in the past, and there was potential for R1 to clip the bracelet off with the clippers. RN-D stated R1 was "very mobile" and "pretty resourceful "and the RoamAlert removal was discussed with the NP for R1's safety. RN-D was unaware of additional attempted interventions prior to him removing the bracelet on 9/13/21. RN-D stated R1's interventions for R1 included also included being on the secured unit, and routine checks, which all residents receive.

On 10/6/21, at 12:05 p.m. registered nurse (RN)-A stated she was the house charge nurse on 10/3/21. RN-A stated RN-B approached her, and asked if she had seen R1, and informed her he was missing. RN-A stated she had not seen R1, and then went to the first floor to search for him. Neither first floor staff nor the receptionist had seen R1. A call then came in from a community member indicating R1 was at Walgreens. The administrator and 911 were notified. About 20 minutes after R1 left the building, TMA-A called from a community member's cell phone and stated she was with R1 at McDonalds. RN-A stated she called the police to update them on R1's location, and then drove to McDonalds to search for R1. RN-A couldn't find

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R1 and TMA-A, and she returned to the facility. RN-A stated when she returned to the facility, she was informed by the receptionist that another call came in from TMA-A stating she and R1 were now at Broadway Pizza (0.6 miles from facility). The police were again updated on R1's location and found R1 and TMA-A at Broadway Pizza. RN-A returned to the floor she was assisting on. A few minutes later RN-A saw a police car entering the parking lot and walked down to the reception area to receive R1. RN-A stated before she got to the door, the policeman left, and R1 was standing between the inner, secured facility door and the outer unsecured door. As RN-A went to unlock the inner door for R1, a family member entered through the outer door, and R1 again exited the facility. RN-A followed R1 and attempted to redirect him; however, R1 would not comply. RN-A called 911 from her cell phone. RN-B came to assist RN-A, got the pizza from R1, and walked back towards the building, and R1 followed. RN-A stated the police returned, and walked with herself, RN-B, and R1 back into the facility. RN-A stated R1 was escorted back to his room. An additional staff was called in to work on R1's unit that evening and be an extra set of eyes. RN-A stated she believed R1 had a RoamAlert bracelet placed two prior times, but he kept removing it.

On 10/6/21, at 12:31 p.m. TMA-A stated she was working on the secured unit when a family member approached her and reported a resident had gotten out about five minutes prior. TMA-A stated she then went down the elevator to look for R1. Without checking in with RN-A or RN-B, or taking her phone, TMA-A went outside and saw R1 "right away" walking past a bus station up the street from the facility. TMA-A later identified in a facility conducted interview R1 was at a bus stop

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bench outside of a church which was approximately 1000 feet from the facility. TMA-A stated she approached R1 and attempted to redirect him; however he refused, became agitated, and continued walking. TMA-A followed R1 past Dairy Queen, to McDonalds, where she borrowed a community members phone to contact the facility. R1 then left McDonalds and TMA-A followed, ending up at Broadway Pizza where she again called the facility. R1 was given a pizza, then the police and RN-B came to the pizza place. R1 was taken by the police back to the facility, RN-B and TMA-A drove back to the facility, and TMA-A returned to the secured unit. TMA-A stated she heard that R1 again left the building, but she was not involved at that time as she had returned to her unit. TMA-A indicated she was not aware of any interactions with a community member at Walgreens.

On 10/7/21, at 8:31 a.m. the DON was interviewed and stated elopement assessments were completed upon admission, quarterly, with a significant change and prior to placement of a RoamAlert. The DON stated they do not complete elopement assessments after removal of a RoamAlert, and they did not complete a new elopement risk assessment on R1 after the RoamAlert was removed on 9/13/21. The DON stated R1 had not displayed exit seeking behaviors for a "long time."

On 10/7/21, at 1:15 p.m. the DON was interviewed again. The DON entered R1's room and verified there were four razors on R1's dresser and stated, "He shouldn't have those." The DON removed the razors. The DON stated R1 had a history of exit seeking behavior. The DON stated there were no additional attempted

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interventions prior to R1 removing the RoamAlert bracelet removal on 9/13/21. The DON verified there was a lack of documentation regarding the rational for removal. The DON verified interventions for R1 included placement of the RoamAlert bracelet, the secured unit, and routine checks which all residents receive. The DON stated they did not implement room searches, 15 minute checks, changing to plastic cutlery, nor did they implement any other interventions after the RoamAlert was removed on 9/13/21. The DON verified scissors were in R1's room on 10/5/21, and a nail clipper on 10/6/21, which could be used to remove the RoamAlert bracelet which could result in another possible elopement. The DON stated daily room checks should be put in place for R1.

R2
R2's Face Sheet printed 10/7/21, indicated R2's diagnoses included adult failure to thrive, anxiety disorder, post-traumatic stress disorder, Alzheimer's disease, dementia with Lewy bodies.

R2's quarterly MDS dated 9/30/21, indicated R2 had a severe cognitive impairment, and required extensive assistance for locomotion on the unit. The MDS indicated R2 exhibited wandering behavior 4 to 6 days during the review period.

R2's CAA for behaviors dated 7/20/21, indicated behavior symptoms included grabbing, screaming, pacing, wandering, and behaviors had worsened since R2's last full assessment.

R2's care plan revised 7/14/21, indicated R2 had a history of laying/sitting on the floor and wandering, and should be reviewed as indicated for significant changes in cognition, safety

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awareness and decision-making capacity.

R2's medical record lacked an elopement risk assessment.

R2's Behavior Monitoring Task reviewed for 7/1/21, through 10/6/21, indicated R2 had exit seeking behaviors on 7/26/21.

On 7/28/21, at 8:23 a.m. a progress note indicated in last 90 days, R2 displayed the following behaviors: 1 exit seeking, and 31 wandering.

On 10/6/21, at 10:45 a.m. R2 was observed wandering in the dining area and common area. At 3:26 p.m. R2 wandered in the common area near the nurse's station and in the dining area. R2 spoke to himself and wandered into the kitchenette area near the exit door, then turned around walked to the nursing station.

On 10/7/21, at 2:06 p.m. the administrator and DON were interviewed. The DON verified R2 did not have an elopement assessment, and stated the elopement assessment tool was not implemented until about two months ago. The DON stated R2 wandered on the unit but was not exit seeking, had no history of elopement, and was not at risk for elopement.

R3
R3's Face Sheet reviewed 10/7/21, indicated R3's diagnosis included anxiety disorder, bipolar disorder, and encephalopathy (brain disease that alters brain function).

R3's significant change MDS dated 9/16/21, indicated R3 had a moderate cognitive

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impairment. R3 required supervision for locomotion on the unit, and had exhibited wandering behavior 1 to 3 days during the review period which did not place him at significant risk of getting to a potentially dangerous place (e.g. stairs, outside of the facility).

R3's care plan dated 7/19/21, indicated R3 had impaired cognitive function or impaired thought processes related bipolar disorder and anxiety exhibited by impaired decision making, and lacks insight into deficits. The care plan updated 8/4/21, indicated R3 had potential for elopement related cognitive loss exhibited by attempts to go to exit door, and cognitive impairment. The interventions for R3's elopement included providing diversionary activity, snacks, and ensure that exit door alarms are in working order.

R3's Kardex printed 10/7/21, directed, "Ensure that exit door alarms are in working order."

R3's elopement assessment dated 9/30/21, indicated R3 was at risk for elopement, and exhibited anger regarding facility placement, elopement attempts in the past, resisting redirection from staff, and was verbally abusive.

R3's Behavior Monitoring Task reviewed for 7/1/21, through 10/6/21, indicated wandering behavior on the following dates 8/17/21, 8/27/21, 9/9/21 and 9/14/21, and exit seeking behaviors on 8/23/21.

On 9/9/21, at 3:46 p.m. a progress note indicated R3 attempted to follow a visitor off the unit but was intercepted by staff who redirected R3 back to the dining area. R3 was agitated and yelling/swearing that he was sick off this and

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wanted out. R3 was to be seen by psychiatry that day.

On 9/13/21, at 11:14 a.m. a progress note indicated R3's elopement attempt was discussed with R3's NP. The progress note indicate R3 was easily agitated, had "intrusiveness" with peers, and had some altercations with other residents. Staff were awaiting recommendations from psychiatry and felt that at this time R3 still required a secure unit.

On 10/6/21, at 10:30 a.m. R3 was observed as he sat in his wheelchair in the common area. R3 stated he was much smarter than most residents on this unit, and had attempted to leave in the past as he did not feel he needed to be in a nursing home setting.

On 10/7/21, at 2:15 p.m. the DON was interviewed and stated R3 had the potential to elope based on the information in R3's care plan, but was not aware of R3's prior elopement attempts. The DON stated R3 did not utilize a RoamAlert. The DON stated interventions in place for R3 prior to his elopement attempt on 9/9/21, included consulting with R3's NP, being seen by psychiatry, and being on the secured unit. The DON stated there were no additional interventions put in place for R3 after his elopement attempt. The DON stated the facility could possibly have implemented a RoamAlert and frequent checks for R3 after he attempted to elope. The DON verified an elopement assessment was not completed for R3 until 9/30/21, and should have been done within a day of any significant change, including an elopement attempt. The DON stated social services completed elopement assessments quarterly;

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however, they could be completed by any staff if needed, and she did not know why it was not completed sooner.

The facility policy Elopement - Rehab/Skilled dated 8/2/21, directed all residents would be assessed for risk of elopement through the pre-admission and or admission process, and as needed. Each location would be responsible to identify residents at risk, evaluate/analyze hazards and risks, implement interventions, and monitor/modify interventions as needed. The facility would put measures in place to minimize the risk of elopement that were individualized to resident needs and identified on the care plan.

The facility document Attention All Visitors to the Arrowhead Dementia Unit undated, directed:
1) Prior to entering or exiting the unit, look around you and through the door window to determine no one is close to the door or following you.
2) Swipe the badge on the square box to the right side of the door. You will hear a loud sound, and a green light will appear above the door 4-5 seconds later.
3) Push the bar on the right hand double door to enter/exit after the green light appears.
4) Wait for the door to close and the red light to reappear above the door before proceeding or leaving the door area.
5) If anyone tries to exit the unit as you enter or exit the unit, immediately notify a staff member.
6) Return your badge to the front desk upon leaving.

The facility implemented corrective action on 10/8/21. The facility reassessed R1 for elopement risk and updated interventions (including a RoamAlert bracelet), R1's room was searched for

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F 689	Continued From page 16 sharp objects and would be searched twice daily, other residents at risk for elopement were reassessed, a plan was made for family members/visitors on the secured unit to be educated prior to their next visit, staff was educated, the Elopement policy was reviewed, and elopement drills were conducted. These interventions were verified though observation, interview and document review.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 22, 2021

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway
Robbinsdale, MN 55422

Re: Event ID: 2SOQ11

Dear Administrator:

The above facility survey was completed on October 8, 2021 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/6/21, through 10/8/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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GOOD SAMARITAN SOCIETY - SPECIALTY CA	**3815 WEST BROADWAY ROBBINSDALE, MN 55422**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 SUBSTANTIATED: H5279104C (MN77302), however, NO licensing orders were issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		