Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 20, 2021

Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

RE: CCN: 245441
Cycle Start Date: June 17, 2021

Dear Administrator:

On July 12, 2021, we notified you a remedy was imposed. On August 9, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 4, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 11, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 12, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 2, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 27, 2021

Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

RE: CCN: 245441
Cycle Start Date: June 17, 2021

Dear Administrator:

On July 12, 2021, we informed you of imposed enforcement remedies.

On July 2, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. 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. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On July 2, 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 G.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 11, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 11, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 11, 2021.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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. 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.

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 § 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 - Albert Lea is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 2, 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.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 - Health Regulation Division 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 December 17, 2021 (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

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.

INFORMAL DISPUTE RESOLUTION/ 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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(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 6/30/21 - 7/2/21, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, the 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 6/26/21, when R1 exited the facility unattended in his electric wheelchair and inflicted self harm approximately one mile from the facility that resulted in death. The facility administrator and director of nursing (DON) were notified of the immediate jeopardy on 6/30/21 at 4:50 p.m. The immediate jeopardy was removed on 7/2/21 at 10:05 a.m.

The above findings constituted substandard quality of care, and an extended survey was conducted from 7/1/21 - 7/2/21.

At the time of the abbreviated survey, onsite investigation(s) were completed and the following complaints were found to be substantiated: H5441057C (MN00074240) with deficiency cited at F689.

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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.

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

Electronically Signed | | 08/02/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

(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	Continued From page 1 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	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 interview, and document review the facility failed to provide adequate supervision and notify law enforcement in a timely manner for 1 of 1 resident (R1) reviewed for elopement that resulted in an immediate jeopardy (IJ). The facility failed to call law enforcement for approximately 34 to 41 minutes once known R1 had been visualized off facility grounds and unable to locate. This resulted in R1 driving his motorized wheelchair on a busy road with a narrow shoulder into town, purchased a knife at a local store and committed suicide. The immediate jeopardy began on 6/26/21, when R1 exited the facility unattended in his electric wheelchair and inflicted self harm approximately one mile from the facility that resulted in death. The facility administrator and director of nursing were notified of the immediate jeopardy on 6/30/21 at 4:50 p.m. The immediate jeopardy	F 689	F689: Plan of Correction: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. 1. R1 expired on 6/26/21. 2. All residents in the facility were reviewed by facility leadership to ensure that an elopement assessment was completed on all current residents in the	8/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2	F 689		

was removed on 7/2/21, but noncompliance remained at the lower scope and severity level of G, isolated which indicated actual harm that is not immediate jeopardy.

Findings include:

R1's facesheet printed 6/30/21, indicated an admission date of 6/16/21, and diagnoses including: paraplegia (caused by damage to the spinal cord and associated with paralysis of the lower part of the body) , pain, anxiety disorder, recurrent major depressive disorder, insomnia, and post-traumatic stress disorder (a mental health problem that can occur after a traumatic event like war, assault, or disaster).

R1's admission Minimum Data Set (MDS) assessment dated 6/22/21, included a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition, and a Patient Health Questionnaire (PHQ-9) score of 6, indicating mild depressive symptoms. The MDS also indicated R1 was totally dependent on staff for transfers, required extensive assistance with bed mobility, dressing, and toilet use; limited assistance with personal hygiene, and independent with eating and locomotion on and off the unit. The MDS further indicated R1 reported almost constant pain rated 9 out of 10, that limited his day to day activities and made it hard to sleep during the night.

R1's care plan initiated 6/17/21, indicated the resident had a mood disorder related to major depressive disorder. Interventions indicated staff were monitoring to determine R1's baseline mood and behavior, and provide him the opportunity to share his feelings and concerns and provide

facility as appropriate to determine if they were at risk for elopement. Care plans were reviewed to ensure appropriate interventions were in place. All new residents will continue to be assessed for risk of elopement at the time of admission.
3. To enhance current compliant operations and under the direction of the Director of Nursing, all facility staff members were provided with education on the facility's policies and procedures regarding
elopement via meetings held on 7/1/21 and 7/2/21. The policies and procedures were reviewed with all staff via meetings held on 7/20/21 and 7/21/21; with all staff to be educated by 8/4/21.
4. Elopement drills to ensure compliance will be conducted by facility administration. Drills will be conducted weekly x 4, then monthly x 3. Elopement drill results/debriefings will be brought to the Quality Assurance Performance Improvement Committee for review and further recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3 reassurance and support as needed. The care plan further indicated R1 was able to mobilize independently in his electric wheelchair. The care plan did not address R1 leaving facility. The facility timeline document titled, June 26, 2021-[R1's full name], indicated on 6/26/21, at 0831 (8:31 a.m.) facility staff were notified that R1 was on the highway. The timeline further indicated at 0905 (9:05 a.m.), 911 was contacted; and at 0913 (9:13 a.m.), 911 was again called. They requested that facility staff come and help them in their search; at 10:35 a.m., the Emergency Department (ED) contacted the facility and notified staff of R1's death. The local PD (Police Department) Incident Report dated 6/26/21, indicated the facility notified PD of R1's elopement on 6/26/21, at 9:13 a.m. On 6/30/21, at 11:15 a.m. an interview with registered nurse (RN)-A via telephone confirmed she worked on 6/26/21. RN-A stated staff alerted her early morning, R1 had requested to get out of bed. RN-A preceded into R1's room and he was adamant to have his dressing change done now and verbalized, "lets go, lets go"; he requested oxycodone [narcotic pain medication] and wanted to wait on the rest of the pills. RN-A stated she took a picture of R1's wound per his request and he asked how much packing was in his wound; she stated she told R1, about 8 inches. RN-A indicated that was when the situation started to get tense. RN-A stated R1 was agitated with her only able to pack 8 inches of gauze into his wound and she proceeded to finish the dressing change. When she told R1 his skin looked irritated he became angry with the products used for the dressing change. RN-A stated R1 was	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4 verbally upset, screamed at her, and she was shaking. R1 indicated to RN-A not to be scared of him and then further requested to get out of bed. RN-A indicated she left R1's room about 7:44 a.m. and within minutes nursing assistants assisted him into his wheelchair. R1 then went outside to the courtyard, which was not unusual. RN-A indicated several minutes later, RN-B proceeded outside into the courtyard and asked R1 if he wanted his breakfast tray saved and if he wanted his medications; R1 requested to be left alone. RN-B went inside; R1 followed her inside the facility and proceeded outside the facility via the therapy doors. RN-A stated the therapy doors were locked from the outside and RN-B unlocked the therapy doors to allow R1 access to return to the facility via the therapy doors. RN-A further indicated a volunteer alerted a front desk staff member, he had seen a guy in a electric wheelchair on the road going down by Hidden Creek (an assisted living facility located next to the nursing home), and RN-A indicated she knew this was not ok. RN-B and NA-B left on foot to search for R1, and RN-C left in her vehicle and tried to locate R1. RN-A stated staff called R1's family member (FM)-A and and left a message to call back and called R1's phone three times with no answer. RN-A stated she then called R1's family member (FM)-B, and the FM-B indicated R1 throws tantrums like this and requested staff wait to call the police and the FM-B would call R1 back. Further, RN-A indicated FM-B called back minutes later, and stated R1 was at Hy-vee [grocery store] and was going to buy a knife and kill himself. RN-A stated she immediately called	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5	F 689		

the police and stated R1's intent. RN-A indicted she called Hy-vee and notified an employee to not sell the knife to R1. The employee stated R1 had already purchased a knife and the police were then notified of the information. The police directed facility staff to continue to search for R1; two staff were sent in one car to search for R1. FM-A then called RN-A back and stated R1 has had mental health issues since a baby, and had threatened suicide before. FM-A stated R1 had called her 4 times that morning but she had her ringer off. FM-A stated R1 had talked to her and stated he was buying a knife at the sports store and going to kill himself though FM-A did not think he would follow through with it. FM-A further indicated to RN-A that R1 had a split personality disorder, and when the bad R1 came out it was really really bad, and now they had met the bad R1. FM-A further stated R1 had promised her he would never do this [kill himself], and stated " I didn't think that he would."

One of the co-workers who left to search for R1 called the facility and stated R1 had cut himself and CPR (cardiopulmonary resuscitation) was being performed. RN-A stated she then notified FM-A, who stated he was in God's hands and he wanted this for a long time. The ED then called and notified the facility that R1 did not survive his injuries; FM-A also called to inform staff that R1 did not survive.

On 6/30/21, at 9:44 a.m. interview with the director of nursing (DON) confirmed R1 could be outside on the grounds on his own, but not off the grounds. The DON stated the resident had a colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall) bag and would go outside to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6 "burp" the bag, and to go around the building. The DON stated once staff found out R1 was off the grounds staff called R1's cell phone but he wouldn't answer. The DON stated then staff reached out to family and the son at first said not to call the police as the resident had temper tantrums and does this all the time. The son was able to talk to R1 via telephone and immediately called the facility back and said to call the police because the resident was buying a knife and had a plan to use it. The DON stated she was at home when she initially found out about the elopement and had said when he came back they would need to put a wander guard (device used to alert staff when resdient leaves building) on resident never thinking this outcome would happen, referring to R1's suicide. R1's progress notes indicated on 6/26/2021, at 7:44 a.m. RN-A documented, nurse entered resident room after knocking and preparing medications. Resident asked to have an Oxycodone first and wait a bit for all other medications. Stated he was waiting for dressing to be completed and then wanted to get up ASAP (as soon as possible). Apologized for the wait, gave the Oxy (Oxycodine), and began the dressing change. Resident requested nurse take a picture of his wound with his tablet after it was cleaned. Staff completed this and he then asked how much packing was in the wound, this nurse reported it was approximately 6-8 inches. He became very agitated at this point stating it was not enough packing, This nurse stated his skin was irritated from tape and he got very agitated stating it is not supposed to be tape, it is supposed to be a sacral Mepilex (a foam dressing). This nurse stated what the orders were and asked if he had discussed it with the NP	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 (nurse practitioner) last week when they went of [sic] his orders. He exploded, screaming and yelling at nurse to "get the ... [inappropriate language] out" stated "he doesn't know what we do he can't feel it" and then stated "you treat me like I don't know anything" This nurse attempted to de-escalate patient after explosive behavior and he continued to yell. He did appear to be less agitated as staff were entering room to get him into wheelchair. Nurse left room at 0744 (7:44 a.m.) and reported incident to weekend manager at 0748 (7:48 a.m.) via message. Resident once up, went into court yard area in electric wheelchair, approximately 30 minutes later different nurse re-approached patient in hopes of a different staff member may be able to have an appropriate interaction and inquire about pain control. Resident stated "leave me alone" wheeled self into the building and out via therapy door at approx. 0830 (8:30 a.m.). On 6/30/21, at 10:28 a.m. the DON stated the facility admission process included a risk assessment for elopement and the assessment indicated he was not an elopement risk. The DON stated R1 was in a motorized scooter and would go outside by himself, and further indicated his medical history did not indicate he was at risk for self-harm. The DON stated a trauma assessment and PHQ [depression screening] was completed at admission and no self-harm was indicated. On 6/30/21, at 12:33 p.m. RN-D indicated she visited with R1 either the 21st or 22nd of June 2021, for the MDS assessment and the resident was in a good mood. The PHQ 9 assessment indicated R1 had difficulty concentrating and little interest in things. RN-D stated having talked to	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 R1's family member (FM)-A last Thursday (6/24/21). RN-D indicated FM-A talked about R1's anger and facility staff hadn't really seen that, as R1 had been pleasant toward staff. FM-A never talked about any suicidal statements; more about anger that was directed at the VA. RN-D confirmed R1 was alert and oriented and staff didn't have any concerns with him going outside independently. RN-D stated if R1 had a diagnosis of wandering or dementia staff would have evaluated further but had no concerns. On 6/30/21, at 2:50 p.m. RN-C confirmed she worked 6/26/21 as the weekend manager. RN-C stated RN-A texted her on 6/26/21, around 8:00 a.m. and notified her a resident just yelled at her. RN-C stated when she arrived to work RN-A and RN-B stated R1 was upset with his dressing change and the dressing order and was outside in the courtyard. RN-C stated staff alerted her R1 had exited the therapy doors. RN-C stated she called RN-D at 8:34 a.m. (who was not working) to determine if R1 was ok outside by himself; RN-D assured her it was. RN-C confirmed volunteer-A had alerted staff R1 was out on the road and did not know the exact location, but stated"by Hidden Creek". RN-C stated when she found out R1 was on the road she got into her car and slowly looked for R1 and drove 30 miles per hour. RN-C stated she directed NA-B and RN-B to walk outside, in opposite directions, and around all 3 buildings to look for R1. RN-C indicated the location she went included, west on highway 13, past the first stop sign, at the top of the first hill turned around, went east to the stop sign, and then south to the plaza by Hy-vee gas, and proceeded east towards town, and then drove north back to the facility.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9 Further, RN-C stated when she arrived to the facility she called R1's cell phone and he didn't answer. RN-C indicated the facility had no indication that R1 had thoughts of self harm. RN-A called R1's family member (FM)-A and she didn't answer and left a voice message to return the call. RN-A proceeded to call R1's FM-B. RN-C stated she called the DON at 8:59 a.m. and the DON directed her to call the police. RN-C stated questioning the DON related to the need to call law enforcement as R1 previously live independently, was a short-stay resident, and dignity was an aspect. RN-C stated the DON again directed RN-C to call law enforcement as R1 was a vulnerable adult, and shouldn't be "toodling" around in his wheelchair. RN-C stated she then told RN-A (who was on the phone with FM-B), the DON wanted staff to call law enforcement. RN-A indicated FM-B wanted to call R1 first prior to law enforcement being notified and staff honored FM-B's wishes. RN-C stated she received a text message at 9:04 a.m. from RN-A that FM-B had notified her that R1 was at Hy-Vee and was buying a knife to kill himself, and FM-B requested for facility to call law enforcement. RN-C stated at 9:09 a.m., RN-A texted RN-C to inform her that R1 was at Hy-Vee buying a knife and she was going to call 911. Then RN-A called Hy-Vee and asked them not to sell R1 a knife. Hy-Vee staff indicated R1 had already gone through the self check out and bought the knife. RN-C and RN-B left the facility in a vehicle to look for R1 and drove behind Hy-Vee, and saw action going on across the street by the mall; subsequently heard on the scanner the location of the incident and drove to where R1 was located. On 6/30/21, at 3:30 p.m. RN-B verified she	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 worked on 6/26/21 and stated she arrived to the facility at approximately 8:05 a.m. RN-A told RN-B that R1 got upset with her during a dressing change and he was currently out in the courtyard. RN-B indicated she worked with R1 the night before and had a great rapport with him. RN-B stated when she heard R1 was upset she went outside to the courtyard and asked R1 if he wanted his breakfast tray saved; R1 told RN-B to leave him alone. RN-B then asked R1 if having any pain; R1 again told RN-B to leave him alone. RN-B then went back inside the facility. R1 followed RN-B inside the facility and then proceeded to then go back outside the facility via the therapy door exit. RN-B stated the therapy doors were routinely locked from the outside so she unlocked the therapy doors to allow R1 access to return to the facility from there. RN-B confirmed when she unlocked the door she didn't visualize R1; RN-B further stated it was probably after 8:15 a.m. that R1 exited through the therapy doors. RN-B stated someone called the DON who asked if staff were sure R1 wasn't still on the grounds. RN-B stated staff searched the grounds but honestly didn't know the timeline and if the DON had been called before or after the search. RN-B stated after she returned to the building after searching the grounds, she was notified that law enforcement had been contacted and had requested staff continue to assist with the search for R1. RN-B and RN-C then left the facility grounds by vehicle to search for R1. RN-B stated they traveled east and drove around to the back of the Hy-Vee grocery store which was across the street from the old mall. RN-B stated they saw some movement in the parking lot of the old mall, then visualized police cars heading fast towards the direction of the mall. RN-B and RN-C then headed over to the mall where R1 was located.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11	F 689		

RN-B stated it was unknown if R1 was a suicide risk or flagged for behaviors.

On 6/30/21, at 3:45 p.m. volunteer-A confirmed having worked the morning of 6/26/21. Volunteer-A stated when coming to the facility he saw a resident outside in an electric wheelchair but didn't know who the resident was. Volunteer-A stated the resident was going east down the little hill past the lower parking lot on the main road, closer to the STOP sign going east. Volunteer-A confirmed upon entering the facility reporting the whereabouts of the resident to the "lady" at the front desk. Volunteer-A further confirmed no other staff had asked him questions related to the resident or the resident's location.

On 6/30/21, at 3:55 p.m. trained medication assistant (TMA)-A confirmed having worked the day shift on 6/26/21. TMA-A further confirmed her shift started at 5:00 a.m. TMA-A stated she passed medications and at about 8:00 a.m. went and worked at the facility's front desk. TMA-A stated volunteer-A entered the facility at an unknown time, and indicated a guy was going down the road on an electric wheel chair. TMA-A stated she called station two and spoke with NA-B who indicated R1 was outside because he was mad and had a rough morning. TMA-A stated she further told NA-B that R1 was on the road. TMA-A then stated RN-C went out the front door to look for R1 and came back about 15 min later. TMA-A stated the only person she gave details about where the volunteer stated he saw R1, was NA-B.

On 6/30/21, at 4:12 p.m. NA-B verified having worked the day shift on 6/26/21. NA-B stated R1 had requested to get out of bed early. NA-B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 notified RN-A, who then proceeded to complete R1's dressing change prior to the resident getting out of bed. NA-B indicated she was in another room and could hear R1 yelling about what type of dressing was being used. NA-B further indicated when RN-A completed the dressing change, NA-B went into R1's room and used a Hoyer lift (mechanical lift) to assist him into his wheelchair. R1 indicated he wanted to get up and get some air outside. NA-B confirmed it was not uncommon for R1 to go outside because he was alert; R1 would usually sit in the courtyard or go around the building in his electric wheelchair. NA-B stated she went to check on R1 outside in the courtyard and he was visibly upset; shaking with red eyes, and asked to be left alone. NA-B stated RN-B checked on R1 some time after that and he also told RN-B to leave him alone. NA-B indicated staff had told her after that R1 had went outside through the therapy door and RN-B indicated having unlocked that door so R1 could get back into the building from there. That was when RN-C went outside to look for R1. NA-B stated she also went outside at approximately 8:30 a.m. to search for R1 looking up and down the road. NA-B further stated she was outside for approximately 2 minutes searching for R1, then went back into the building and went on her break. NA-B stated when she returned from her break, RN-C had also returned to the facility after searching for R1. RN-C called the DON who advised staff to call law enforcement. The DON further instructed NA-B and RN-B to walk in separate directions to search for R1. NA-B stated they walked around the facility and also the other facilities that were close by. When NA-B and RN-B returned to the facility they were told R1 was buying a knife; RN-B and RN-C then left in a vehicle to search for R1. NA-B was unsure	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 what time that was. On 6/30/21 at, 4:30 p.m. the DON confirmed she did not interview volunteer-A or TMA-A related to R1's elopement on 6/26/21. On 6/30/21, at 4:36 p.m. during follow up interview with RN-B stated a volunteer told the the front desk staff he saw a person outside in an electric wheel chair. RN-B stated the front desk staff called her right away, and asked if we had a guy in an electric wheel chair and she said he was on the road by hidden creek. RN-B stated she immediately told her manager RN-C, that R1 was in the road by Hidden Creek. RN-B stated Hidden Creek was towards the west and indicated in her mind I thought he would be going west. RN-B stated no one from the facility went and looked east for R1 and further indicated RN-C went in her car and drove west and did a full circleback to the facility, and made a solid loop. The policy titled Elopement, reviewed revised 10/30/20, indicated: Elopement Search 1. In the event of a suspected missing resident: a. If the resident commonly goes out of the building with family members, check the sign in/out book at the nurses's station. Also check locations the resident would frequently spend time in. b. If unable to locate the resident, immediately notify the administrator, DNS (director of nursing services) and charge nurse or their designees. c. A lead person will be assigned to be in charge of the missing resident search and will assemble a search team. Members of the search team will consist of available employees who can leave their assignments without adversely affecting the remaining residents. d. Employees will be	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14 assigned areas to search upon direction of the lead person. When finished searching their assigned area, employees will report back to the lead person in charge of the search. e. All areas within the building, the grounds and neighboring areas will be searched. If needed, begin an organized, assigned street search and, dependent upon staffing, send at least one person from each unit to search. The charge nurse must stay in the building. f. If the resident is found, the lead person will notify employees on duty the resident has been found. The resident will be evaluated for injuries and the physician or 911 will be contacted as appropriate. g. If the resident cannot be located within a reasonable amount of time, the lead person will notify law enforcement to assist with the search. When law enforcement arrives, staff members will be ready to provide description of the resident, such as: age, weight, height; what the resident was wearing, any assistive devices the resident uses; the resident's cognitive status; any information regarding tips as to where the resident might be going, etc.; identification available i.e., picture. h. In all cases, family will be notified of the incident. i. Notify the physician. j. Notify other agencies as required by state and/or federal regulation. k. Call the Critical Incident Hotline for resident elopement that requires outside medical treatment, hospitalization, results in a death or if the resident is not located after one hour. The immediate jeopardy that began on 6/26/21, was removed on 7/2/21, when the facility educated all staff on elopement procedures. The facility also identified all residents who were at risk for elopement, developed. and implemented interventions to ensure residents at risk for elopement were safe and identified those	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET** **ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15 residents who were at risk for serious adverse outcomes as any resident who resided in the facility. Any resident who was identified as at risk for elopement would be addressed according to facility policy and any resident who resided in the facility would continue to be monitored for signs or behaviors of elopement risk and would be re-assessed as appropriate. Noncompliance remained at the lower scope and severity level of G, isolated which indicated actual harm that is not immediate jeopardy.	F 689		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
July 27, 2021

Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

Re: Event ID: YK5911

Dear Administrator:

The above facility survey was completed on July 2, 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00131	A. BUILDING: ______ B. WING ______	C **07/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET** **ALBERT LEA, MN 56007**

(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	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/30/21 to 7/2/21, 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		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Electronically Signed 08/02/21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00131	A. BUILDING: ______ B. WING ______	C **07/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET** **ALBERT LEA, MN 56007**

(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: H5441057C (MN00074240) however NO licensing orders were issued. 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		