Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 20, 2025

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

RE: CCN: 245441
Cycle Start Date: February 11, 2025

Dear Administrator:

On February 24, 2025, we notified you a remedy was imposed. On March 19, 2025 the Minnesota Department of Health 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 March 12, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 11, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 24, 2025, 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 February 11, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 24, 2025

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

RE: CCN: 245441
Cycle Start Date: February 11, 2025

Dear Administrator:

On February 11, 2025, a survey was completed at your facility by the Minnesota Department(s) 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On February 5, 2025, the situation of immediate jeopardy to potential health and safety cited at F600 was removed.

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(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 11, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 11, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 11, 2025.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- 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 February 11, 2025. 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.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response

Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

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 August 11, 2025 (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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

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February 24, 2025

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

Re: Event ID: 6PFS11

Dear Administrator:

The above facility survey was completed on February 11, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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 02/11/2025

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 On 2/10/25 and 2/11/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaints were reviewed H54417110C (MN00110508) and H54416921C (MN00110474 and MN00110446) and a deficiency was issued at (F600) at PAST NON-COMPLIANCE and 609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		

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

Electronically Signed | 03/05/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to protect 2 of 2 female residents (R2, R1) resident's right to be free from sexual abuse and sexaully inappropriate behaviors by male resident (R3). This deficient practice resulted in an immediate jeopardy (IJ) for R1 who had severe cognitive impairment and unable to give consent, however, a reasonable person would have experienced severe psychosocial harm-dehumanization, and humiliation as a result of the sexual abuse. The immediate jeopardy (IJ) began on 2/5/25, at approximately 10:00 a.m. when R3 was in the dining room unsupervised and found rubbing R1's breasts who was unable to leave the area on her own. The IJ was identified on 2/11/25, and the administrator was notified of the IJ on 2/11/25, at 6:00 p.m. The facility had implemented immediate corrective action on 2/5/25 to prevent recurrence, so the IJ was issued at past non compliance. Findings include: R3 Admission Record printed 2/10/25, identified diagnoses of dementia, major depressive disorder, and osteoarthritis. R3's admission MDS dated 11/7/24, indicated R3 had severe cognitive impairment with a behavior	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

of wandering. R3 was independent with bed mobility, transferring, ambulating with a walker.

R3's Progress notes indicated the following:

Review of R3's progress notes between 1/18/25 through 2/2/25 identified R3 displayed sexually inappropriate behaviors toward staff on 1/18/25, 1/24/25, and daily between 1/26/25 through 2/2/25; some of those days R3 had behaviors more than once. R3's sexual behaviors included, walking out of his room exposing his genitals, attempting to touch female staff inappropriately, and sexual advances and innuendos directed at female staff. Examples included but were not limited to:

-1/18/25 at 7:17 a.m. R3 found wandering in the hallway naked during the night shift and gets handsy with CNA (nursing assistant-NA) and asked if she wanted to sit on his lap.
-1/24/25 9:00 p.m. R3 was wandering multiple times out of his room during the evening shift. R3 was also "very touchy" to staff and touching staff's waist and back, trying to touch front of staff.
-1/28/25 at 2:16 p.m. R3 wandered out into the hall with his pants down. Staff redirected him and he was reaching out, trying to grab staff inappropriately. 1/29/25 at 5:08 a.m., R3 was making odd noises and wandering this shift, was in the hall with his pants down and asked the NA "do you want to touch my butt?"
-1/30/25 at 5:24 p.m. R3 started to masturbate in the main dining room. Staff escorted R3 back to his room. Progress note at 9:00 p.m. R3 was grabbing at NA's peri area during HS (nighttime) cares.
-1/31/25 at 7:04 a.m. R3 wandering in the hallway and stepped into the hallway with his brief and

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F 600	Continued From page 3 pants down. R3 redirected back to his room. Progress note at 3:47 p.m. R3 had sexual behaviors during the shift. R3 was walking out in the hall and playing with his penis with his pants down, grabbing at staff. -2/1/25 at 9:00 p.m., multiple behaviors this evening shift. R3 wandering multiple times, wandered into (room number identified- another female resident's) room, wandered to station 4 (four), wandered down the hallway multiple times (twice with his brief and pants down). NA reported R3 was grabbing NA's thigh as she assisted back to his room and asked staff if they wound (sic) go to bed with him. -2/2/25 at 9:00 p.m., R3 was wandering out of his room this evening shift and grabbing at staff's peri areas when staff assisted him back to his room. Staff asked him to stop, and he stopped. R3's record reviewed between 1/18/25 through 2/2/25 identified a new onset of sexualized inappropriate behaviors towards staff in and outside of public areas. The physician was not notified of the new behavior until 10 days after R3 displayed sexual behaviors. There was no indication a comprehensive assessment that identified female residents may be at risk, along with developing and implementing appropriate measures as a result of R3's sexual behavior. R3's care plan was not updated to identify R3's sexually inappropriate behaviors. A facility reported incident (FRI) submitted to the state Agency (SA) on 2/4/25 at 1:20 p.m., indicated on 2/2/25 at 9:53 p.m., R3 was found lying next to R2 in her bed. R3 may have been attempting to masturbate while in R2's bed. R2's Admission Record printed 2/10/25, identified	F 600		

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F 600	Continued From page 4 diagnoses of dementia, Parkinson's disease, anxiety disorder, and epilepsy. R2's MDS dated 1/31/25 indicated R2 had severe cognitive impairment with no behaviors. R2's vulnerable adult assessment dated 1/24/25 identified R2 was vulnerable due to her inability to ambulate without a device, unable to report abuse/neglect concerns; confused to person, place and/or time; forgetfulness; varied cognition; high anxiety level; disruptive; and thought or mood disorder that impair judgement. R2's Progress Noted dated 2/2/25 at 9:50 p.m., identifies a resident-to-resident incident report filed on elder, director of nursing informed of the incident, (family member) informed of incident The note indicated R3 was added to the list for physician rounds. R3's progress note dated 2/2/25 at 9:50 p.m., R3 was found lying in R2's bed next to her. Progress note at 9:59 p.m. identified a soft touch call light placed next to R3's right hip as intervention due recent incident. During observation and interview on 2/10/25 at 2:40 p.m., R2's room had a mesh banner across the midway of her door. R2 was sitting with her family member watching television in her room. R2 had difficulty completing her thoughts and sentences. During an interview on 2/10/25 at 4:20 p.m., R2's family member (FM)-A indicated the facility had notified her of an incident on 2/2/25 of a man masturbating while in bed with R2. Further indicated R2 would not likely remember what happened and did not want R2's FM-D to know as it would be upsetting to him. FM-A further	F 600		

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F 600	Continued From page 5 stated the facility did not reveal who the man was, but the family knew who he was because R3 wandered into R2's room "several" times while family was visiting, and they would tell him to leave. FM-A stated in R2's "diminished confusion, she[R2] may not have really understood what was happening but would have been horrified and felt very violated if someone was in her bed and it was not her husband". FM-A stated R2 was "paranoid" and would be "upset and worry about it and ruminate about it." During an interview on 2/11/25 at 11:50 a.m., licensed practical nurse (LPN)-A indicated she was working the night of 2/2/25 and responded to R2's call light. Further identified when she found R3 laying next to R2 on top of the covers with his pants halfway down and in the process of masturbating. R2 was lying on her side, under the covers with clothing intact and appeared to be sleeping. LPN-A stated R3 bumped the soft touch call light when he got into R2's bed. NA-B removed R3 from R2's room without difficulty and LPN-A observed R2 for any injuries and found none. LPN-A made the proper notifications and implemented soft touch call light next to R3 in bed to alert staff when he got out of the bed. LPN-A stated she was "shocked." LPN-A identified R3 to have a history of wandering into other resident's rooms and trying to touch staff's groin and legs. Further stated R3 moved fast so staff checked on him more frequently and put the mesh stop sign banner on R2's doorway and closed her door. R3's progress note dated 2/4/25 at 1:29 p.m. discussed with R3's family member of concerns of recent behaviors and wandering. Will continue to assist R3's family in discharge planning and memory care placement. Progress note at 3:00	F 600		

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F 600	Continued From page 6 p.m. R3 was standing at the doorway of his room with his pants down masturbating. Staff redirected him back to his recliner. R3 was trying to grab at staff. In review of R3's record there was no indication after the incident with R2 that a comprehensive assessment was completed to determine R3's level of supervision to protect other female residents from R3's sexually inappropriate behaviors. R3's behavior care plan last revised on 2/4/25, The care plan included R3 displayed inappropriate sexual advances towards staff related to dementia as evidenced by grabbing at staff's buttocks and breast, verbalizing sexual comments, and exiting room with penis exposed. There was no indication of what level of supervision of R3 was required to protect female residents. Interventions included: -contact health care provider to report new behavior and seek input; -consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate, -utilize a consistent staff approach; provide involved residents with opportunities for socialization in supervised areas; -attempt non-pharmacological interventions. -provide resident with redirection on inappropriate behavior. Attempt to give resident something to do with hands while completing cares. State to resident "your wife, [name of wife], would not appreciate this." -direct resident to private space if masturbating. Provide adult content magazine to encourage	F 600		

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GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

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F 600	Continued From page 7	F 600		

resident's self-gratification to occur in resident's room.
R3's care plan did not include "stop sign" as an intervention.

R1's Admission Record, printed 2/11/25, identified diagnosis that included dementia, major depressive disorder, and parkinsonism (brain condition that causes slowed movements, stiffness, and tremors). R1's significant change Minimum Data Set (MDS) dated 12/24/24, identified R1 had severe cognitive impairment with no behaviors. The MDS indicated R1 required staff assistance for activities of daily living. R1's Minnesota Vulnerable Adult Assessment dated 12/3/24, indicates R1's vulnerabilities included inability to ambulate without a device, visual defects, confused to person, place, and/or time; forgetfulness; and thought or mood disorder that impair judgement.

A FRI submitted to the SA on 2/5/25 at 12:14 p.m., indicated R3 left his room and went to the dining room station unsupervised where he reached over R1's back and placed his hands under R1's shirt.

R1's Progress Notes on 2/5/25 at 5:17 p.m., indicated communication with family regarding incident from today with another resident and he had no concerns/questions. The progress note did not identify what incident occurred or R1's reaction to R3's inappropriate touching.

During observation and interview on 2/10/25 at 4:35 p.m., R1 appeared sleeping in her bed and a man who identified himself as R1's family member (FM-B) was sitting in a recliner watching television. FM-B stated the facility made him

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F 600	Continued From page 8 aware of a man touching R1 where he should not, but hoped R1 did not realize what happened to her. FM-B further indicated he wanted to know who the man was, but the facility would not tell him and stated, "it is upsetting, and I do not want to talk about it anymore." During an interview on 2/11/25 at 11:58 a.m., NA-A stated R3 "got grabby with the CNA's" and indicated after the 2/2/25 incident staff were told to do 15-minute checks on him. NA-A further identified she was working on 2/5/25, and she was walking out of another resident's room and heard R1 saying "stop, stop" and witnessed R3 standing to the back left side of R1 with his right hand inside her shirt with his hand on R1's breast and had to remove R3's hand from R1's shirt and remove him from the area. NA-A indicated she had seen R3 prior to the incident, "it all happened within a 3 minute time span". NA-A stated RN-A immediately notified the SW and DON and R1 told them there "was a guy who grabbed her boobs". NA-A identified R3 has had 1:1 staffing since the second incident. R3's progress note dated 2/5/25 at 1:39 p.m. order to send to emergency room (ER) via ambulance for altered mental status-elevated white blood cell count. R3's care plan was revised on 2/5/25 to reflect R3 will have 1:1 with staff. R3's Emergency Medicine Discharge Instructions dated 2/6/25 at 11:41 a.m., indicated R3 was discharge with the following diagnoses: change in mental status, behavior sexual high-risk heterosexual, and dementia. Discharge orders were for Seroquel (antipsychotic medication) 12.5	F 600		

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F 600	Continued From page 9 mg twice a day and follow patient closely 1:1 [supervision]. R3's progress note dated 2/6/25 at 2:01 p.m. R3 returned to facility from ER. During observation and interview on 2/10/25 at 4:55 p.m., R3 was observed sitting in a recliner in his room. R3's door had a mesh stop banner about midway up the door and a staff person sitting just outside the doorway. R3 appeared sleepy and spoke in partial sentences unrelated to the topic of conversation. During an interview on 2/11/25 at 11:45 a.m., R3's family member (FM)-C indicated the facility notified the family of the incident's on 2/2/25 and 2/5/25 with two female residents. FM-C further indicated R3's sexual behaviors just started a few weeks prior to those incidents and felt most of R3's wandering behaviors were because he was looking for a bathroom but was put on medication after the incident on 2/5/25 and has 1:1 staff now. FM-C questioned the level of supervision at the time of the incidents. During an interview on 2/10/25 at 2:45 p.m., registered nurse (RN)-A . R3 had a "sudden onset" of sexual behaviors that were directed at staff which included exposing himself in shared areas of the facility, attempts at inappropriate touching, and statements were directed at staff. RN-A described the incident on 2/2/25 as R3 was masturbating in R2's bed while R2 in it. After the incident with R2, staff put a mesh stop sign banner on his door to deter R3 from exiting his room without assistance, put a soft touch call light next to him to alert staff when R3 got up, and implemented more frequent checks. RN-A	F 600		

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F 600	Continued From page 10	F 600		

defined more frequent checks as more frequently than hourly. RN-A described R3 as "quick and very quiet" and should have stand by assistance when walking outside of his room but frequently self-transferred. RN-A stated on 2/5/25 at approximately 10:15 a.m., R3 went underneath the stop sign unwitnessed and went to a shared sitting area where R3 approached R1 from the back. He reached over her back and put his hands down her shirt and touched R1's breasts. The facility then sent R3 to the ER for evaluation and upon R3's return to the facility, 1:1 direct supervision was implemented. The facility had also implemented daily behavior/mood observations of R1 and R2 and both appear at their baseline.

During an interview on 2/11/25 at 10:20 a.m., social worker (SW) indicated R3 had advanced dementia and a behavior of wandering, but the sexual behaviors began suddenly. Further indicated the sexual behaviors started as an occasional comment to staff then became more of a daily occurrence then advanced to exposing himself in public areas. The SW further identified they communicated with family and put interventions and "scripting" (short and simple set of instructions or phrases that automate responses) in place. The SW further identified after the incidents, R1 and R2 were monitored daily for mood and behavior and have not noted any psychosocial changes and R3 received 1:1 staffing at all times.

During an interview on 2/11/25 at 11:25 a.m., the director of nursing (DON) indicated R3's sexual behaviors prior to 2/2/25 did not affect other residents and did not wander into other resident's rooms. After the 2/2/25 incident when R3 was

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F 600	Continued From page 11 found in R2's bed, the facility implemented mood monitoring for R2; mesh stop sign banner across R2 and R3's door; soft touch call light by R3, provided R3 with adult content magazines in room, and more frequent checks. The DON defined his expectation of more frequent checks as "eyes on [R3]" every 15 minutes. The DON stated the interventions appeared to work "until they didn't" identifying that on 2/5/25, R3 went under the mesh stop banner and nursing assistant (NA)-A heard R1 saying "no, don't touch me", "he touched my boob", and swatting R3's hands. DON indicated according to staff interviews R3 had been visualized by NA's 5-10 minutes prior to the incident with R1. The DON indicated he was notified immediately. DON directed immediate 1:1 direct supervision staff for R3, physician and family notifications, R3 was transferred to the ED for evaluation. During a follow up interview on 2/11/25 at 4:10 p.m.,, the DON and SW indicated they were not aware that R3 had a history of wandering into other residents rooms and R2 was supposed to have a mesh stop sign in place prior to the 2/2/25 incident but was not sure if it was up or not. Further identified they wanted to go with the least restrictive intervention as they did not think R3 would like someone watching him all the time. The facility did not do a comprehensive individualized assessment of the interventions that they put in place and did not assess if R3 could remove the Velcro mesh stop sign banner at the doors. The DON verified the point of care documentation did not reflect 15-minute checks until a 15-minute check form for R3 was implement on 2/3/25 at 3:00 p.m. (approximately 17 hours after the 2/2/25 incident) and have continued since then.	F 600		

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F 600	Continued From page 12 The facility policy titled, Abuse and Neglect last reviewed/revised 7/22/24, indicated the resident has the right to be fee from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subjected to abuse by anyone, including but not limited to, employees, other residents, consultants or volunteers, employees of other agencies servicing the individual, family members or legal guardians, friends, or other individuals. If it is an allegation of resident-to-resident abuse, the residents will be separated immediately, and both ensured a safe environment. The past noncompliance immediate jeopardy began on 2/5/25. The immediate jeopardy was removed, and the deficient practice corrected by 2/5/25, after the facility implemented a systemic plan that included the following actions: - The facility implemented a plan to ensure R3 had direct 1:1 supervision at all times. -All nursing staff were provided with education and expectations pertaining to R3's care plan interventions and supervision. - Audits have been initiated to ensure R3 had direct 1:1 supervision at all times. - Facility updated R1, R2, and R3's care plan and provided education to staff on changes and updates.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		3/12/25

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F 609	Continued From page 13 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report an allegation of abuse timely to the State Agency for 1 of 2 residents (R2) reviewed for allegations of abuse. Findings include: A Nursing Home Incident Report (NHIR) submitted to the SA on 2/4/25 at 1:20 p.m., indicated on 2/2/25 at 9:53 p.m., R3 was found lying next to R2 in her bed. R3 may have been attempting to masturbate while in R2's bed. Submitted approximately 40 hours after the alleged incident.	F 609	2567 Received Date: February 24, 2025 Center: Good Samaritan Society-Albert Lea Team Leaders: Tony Janusz, Administrator; Randy Huls DNS; Jazmin Johnson QAPI/IP Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed	

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F 609	Continued From page 14 R2's Admission Record printed 2/10/25, identified diagnoses of dementia. R2's quarterly Minimum Data Set (MDS) dated 1/31/25, indicated R1 had severe cognitive impairment with no behaviors. R2's Minnesota Vulnerable Adult Assessment dated 1/24/25, indicates R2's vulnerabilities included inability to ambulate without a device and self-propel the wheelchair; unable to report abuse/neglect concerns; confused to person, place and/or time; forgetfulness; varied cognition; high anxiety level; disruptive; and thought or mood disorder that impair judgement. R3 Admission Record printed 2/10/25, identified diagnoses of dementia. R3's admission MDS dated 11/7/24, indicated R3 had severe cognitive impairment with a behavior of wandering. R3 was independent with bed mobility, transferring, ambulating with a walker. During an interview on 2/11/25 at 11:50 a.m., licensed practical nurse (LPN)-A indicated she was working the night of 2/2/25 and responded to R2's call light at approximately 10:00 p.m. Further identified when she found R3 lying next to R2 on top of the covers with his pants halfway down and in the process of masturbating. R2 was lying on her side, under the covers with clothing intact and appeared to be sleeping. LPN-A notified the DON, family, and provider. Email communication dated 2/12/25 at 6:09 p.m., the administrator identified the facility would normally report alleged abuse without immediate	F 609	solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F609: Reporting of Alleged Violations 1. Events of abuse and/or neglect for residents R1, R2, R3 will be reported immediately or no less than 2 hours if they involve abuse or result in serious bodily injury. If abuse or serious bodily injury does not happen then the event will be reported within twenty-four hours. 2. All residents have the potential to be affected by the deficient practice. Specifically, residents who may be a victim of abuse or neglect within the care center. All events of abuse and/or neglect will be reported to the appropriate agencies within two hours if it is abuse or if there is serious bodily injury. If the event does not involve abuse or serious bodily injury, then it will be reported to the appropriate agencies within twenty-four hours. 3. To ensure systemic changes are sustained education on the Abuse and Neglect Rehab/Skilled, Therapy & Rehab policy and procedure will be given to all staff through education huddles starting on February 28, 2025, and will conclude on March 7, 2025. This education will ensure that all events can be reported within the appropriate time frame and to	

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F 609	Continued From page 15 jeopardy within 24 hours but was informed on 2/3/25 that the DON and regional clinical service nurse determined the incident did not need to be reported because there were no signs of willful intent or injury. The administrator then identified after further discussion of the 2/2/25 incident, she instructed the DON to submit a report to the SA and the report was finalized and submitted to the SA on 2/4/25. The facility policy titled, Abuse and Neglect last reviewed/revised 7/22/24, indicated the resident has the right to be fee from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subjected to abuse by anyone, including but not limited to, employees, other residents, consultants or volunteers, employees of other agencies servicing the individual, family members or legal guardians, friends, or other individuals. If it is an allegation of resident-to-resident abuse, the residents will be separated immediately, and both ensured a safe environment. If there is an allegation of abuse, neglect, exploitation or mistreatment of resident property, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made. If there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported not later than 24 hours after the allegation is made.	F 609	the appropriate agencies. 4. The corrective action listed above will be monitored by the DNS/Administrator via audits that will be completed twice a week for four weeks and then weekly for four weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained. 5. The date for correction will be March 12, 2025	