DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2022

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

RE: CCN: 245558
Cycle Start Date: September 30, 2022

Dear Administrator:

On October 18, 2022, we notified you a remedy was imposed. On November 17, 2022 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 September 30, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 2, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 18, 2022, 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 September 30, 2022. 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, 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

An equal opportunity employer.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 12, 2022

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

Re: Reinspection Results
Event ID: 463P12

Dear Administrator:

On November 17, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 30, 2022. At this time these correction orders were found corrected.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
October 18, 2022

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

RE: CCN: 245558
Cycle Start Date: September 30, 2022

Dear Administrator:

On September 30, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On September 30, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 2, 2022.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 2, 2022 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 2, 2022, (42 CFR 488.417 (b)).

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. 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 Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - Windom is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 30, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 30, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132

Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 18, 2022

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

Re: State Nursing Home Licensing Orders
Event ID: 463P11

Dear Administrator:

The above facility was surveyed on September 28, 2022 through September 30, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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.

Please feel free to call me with any questions.

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
	245558	A. BUILDING _____ B. WING _____	C 09/30/2022

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

(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 Surveyor: 34083 On 9/28/22 through 9/30/22, 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 the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F689 began on 9/23/22, when R1 exited the facility without staff knowledge or supervision. The administrator, and director of nursing (DON) were notified of the IJ on 9/29/22 at 5:04 p.m. The IJ was removed on 9/30/22 at 3:20 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 9/30/22. The following complaints was found to be SUBSTANTIATED: H55584821C (MN87077). 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 substantial compliance with the regulations has been attained in accordance with	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/20/2022

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
	245558	A. BUILDING _____ B. WING _____	C 09/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 1 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: Surveyor: 34083 Based on interview and document review, the facility failed to ensure comprehensive assessments were completed and interventions implemented for 1 of 3 residents (R1) who eloped from the facility into an unsafe area. This failure resulted in an immediate jeopardy (IJ) when R1 left through the facility's front door on 9/23/22 without staff knowledge, tipped his wheelchair off the curb and fell on his side onto the driveway. R1 sustained a minor injury of a scraped right knee and skin tear to his right elbow. The IJ (Immediate Jeopardy) began on 9/23/22, at 1:00 p.m. when R1 had fallen from his wheelchair (w/c) after having gone outside without staff knowledge into an unsafe area within feet of a steep decline which led directly to a river. The director of nursing (DON) and administrator were notified of the IJ on 9/29/22, at 5:04 p.m., which was identified as a J-ISOLATED. The IJ was removed on 9/30/22 at 3:20 p.m., but non-compliance remained at the lower scope and	F 689	Good Samaritan Society-Windom Plan of Correction Sept 28-30, 2022 Survey What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice Immediately after the incident on Sept.23, 2022, R1 was brought to his station by the nursing assistants where a Wanderguard pendant was applied. At the same time, an elopement assessment was completed for R1 with care plan interventions added. A comprehensive assessment, including an elopement assessment and a root cause WHY analysis was completed for R1 on Sept. 29, 2022, with additional interventions identified and care planned. Potential root causes identified include: Alzheimer's Disease, Depression, and Loneliness. The following approaches will be reviewed and trialed for success.	9/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 09/30/2022

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

(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 severity of D-ISOLATED, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Review of the 9/23/22 at 2:42 p.m., State Agency (SA) Report identified R1 went out the front entry door onto the sidewalk in his w/c where 2 unidentified visitors observed R1 fall to the side in his w/c and notified facility staff. Staff immediately responded and R1 was discovered to have received a scrapped right knee and skin tear on his right elbow. R1 reported he wanted to see his wife when asked where he had been going. A wander guard device was placed on R1's w/c upon his return to the facility. Review of the 9/28/22 at 6:54 p.m., 5-day SA report identified 9/23/22 as the first time R1 had attempted to leave the facility. R1 was able to move independently in his w/c and his normal pattern was to wheel around the facility many times during the day. It was reported R1 wheeled himself in the main hallways and sat in the reception area by the main entrance to visit with staff, watch the birds or take a nap. The report identified he often spoke of his wife but had not made any attempt to leave the facility to find her. Unidentified staff reported R1 had been observed passing by in the hall four times that morning and he had reported he was "looking for his wife to visit". Unidentified staff attempted to redirect R1, and he had replied, "I think she is coming back". There was no mention staff identified R1 required increased supervision to prevent his elopement out through the front door. Observation on 9/28/22, of the main entrance of	F 689	New Approaches: • Provide all meals in the smaller, quiet, north dining room (closer to his room) • Approach resident in calm manner, with positive facial expressions and pleasant voice • Consult with spouse about resident not having a roommate • Offer resident opportunity to call his wife daily and as needed • Allow resident to awake naturally in the morning • Ensure all staff are aware resident is at high risk for elopement • When exit seeking behaviors are exhibited, provide 1 to 1 monitoring How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the same deficient practice. All residents' assessments were reviewed and as a result, 9 additional residents (R2-R10) were identified as at potential risk for similar deficient practice based on elopement seeking or wandering patterns of behavior. These residents have had a comprehensive assessment, including elopement, completed with care plans reviewed and updated as needed. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(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 the facility identified the main entrance door was covered with an overhang and the drive way curved to allow motor vehicles access to pick up and drop off residents in front of the entrance doors. To the left of the doors the sidewalk curved along the drive and immediately began sloping down out of the parking area to the street which had a steep decline that formed a T with a guardrail at the bottom of the slope. A steep hill was on the other side of the guardrail and dropped steeply to the river at the base of the hill. Had R1 not tipped over in his wheelchair, he could have reached the road, with the potential of his chair picking up speed on the slope and possible crashing into the guard rail and been injured or been thrown over the rail and down the steep hill. The main entrance area has the potential for heavy traffic which increased the risk for serious injury if a resident were to exit in front of an incoming or exiting vehicle. Review of video footage of the elopement on 9/23/22 with review beginning at 12:56 p.m. identified: 1) Camera #1 showed R1 propelling himself in his w/c past the unoccupied receptionist desk towards the front door. He stopped just shy of the door and appeared to watch an unidentified person enter and walk past him. At 12:57 p.m. R1 proceeded to the door, pushed open the first door into the entry, and proceeded to push open and exit the outer door onto the sidewalk area. He turned his chair to the left and went out of camera range. Staff and visitors were observed walking in the area, but no one indicated they were aware R1 had exited the building. At 12:59 p.m., a female visitor quickly entered through the doors and went to the reception area where she	F 689	Organization's policy on comprehensive assessments and elopement has been reviewed and is current. All licensed staff have been educated on assessments and elopement care planning interventions. A licensed staff who completes a mood and behavior note regarding wandering or elopement seeking behaviors will review the resident's current plan to assess for an elopement focus. If there is one, they will review and update interventions as appropriate. If there is not an elopement focus, they will complete an elopement assessment. Additionally, this nurse will notify the Social Worker or Case Manager that they have completed an Elopement Assessment. All employees will receive education in one of 2 methods: Attend a group learning session on Sept. 30, 2022 at 10am or 11am or will receive personal education prior to their next shift. The education topics include: • Review of our elopement policy • Elopement UDA for licensed staff • Assessments of elopement for licensed staff • Identification of change in condition • Reporting elopement behaviors • Elopement care plan interventions Education provided by: GSS LEAD staff on Sept. 30, 2022 and facility charge nurses for those unable to attend the scheduled learning sessions. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice.	

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	245558	A. BUILDING _____ B. WING _____	C 09/30/2022

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F 689	Continued From page 4 called for assistance. A second unidentified person entered through the main doors and went down the administrative hall to summon assistance. At 12:59 p.m. Nursing assistants (NA)-A and B were observed running from the office behind the reception desk and out the main door. Immediately following the administrator and Chaplin were observed responding to the summons and they exited out the front door. At 1:01 p.m., nurse aide (NA)-A was observed transporting R1 back into the building in his w/c and proceeded down the hall toward the 200-wing nursing station. 2) Camera #2 revealed at 12:58 p.m., R1 exited onto the sidewalk outside the main door, turned his w/c left (toward the driveway with the steep incline), appeared get his w/c wheel stuck on the curb and had some difficulty getting it loose and then R1 self-propelled out of camera view. At 1:01 p.m. R1 was transported back into building seated in his w/c by NA-A. R1's 6/2/22, quarterly Minimum Data Set (MDS) identified he had severe cognitive impairment and wandered. This continued in the 9/9/22, quarterly assessment which further identified he required extensive assistance of 1 staff for all activities of daily living (ADLs). R1 had identified behaviors of verbal and physical behavior directed toward others, wandering, and refusal of care. R1's diagnoses included progressive neurological conditions, Alzheimer's disease, and depression. Review of the medical record identified R1 had been admitted to the facility on 12/9/2019, but no elopement assessment was completed until following the incident on 9/23/22.	F 689	The following audits will be conducted by the QAPI Coordinator or designee, weekly on a sample of residents for 13 weeks with the RAI process providing the resident sample. i. An audit of mood and behavior notes will be completed to identify any unidentified wandering or exit seeking behaviors. ii. An audit of elopement assessment completion will be conducted to assure the elopement assessments are completed in accordance with policy. Findings will be shared with the QAPI committee monthly x4 months for input on the need to increase, decrease or discontinue audits. The date for correction and the title of the person responsible for correction of deficiency. 9/30/22 by OCDNS or designee	

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F 689	Continued From page 5 Review of R1's undated care plan failed to identify R1's behaviors of physical and verbal agitation, wandering through out the facility, and his lack of safety awareness with interventions to address the areas of concern due to his severe cognitive impairment. R1's progress notes revealed: 1) 4/15/22 at 3:56 p.m., R1 told staff, "my wife Judy is coming to take me out for dinner". He attempted to leave by the front door. Staff returned him to the North end and provided reassurance he was to have his meal at the facility. 2) 4/27/22 at 1:44 p.m., R1 was noted to be upset, stating "I don't know where [spouse] is...she is taking me home today". R1 was then noting to be "wheeling himself up and down halls on North end of building". 3) 6/4/22 at 1:19 p.m. R1 became upset and wheeled himself to center desk asking, "Where's my wife?" Was told by staff she was not there right now and became upset yelling, "don't' lie to me" I know she is here, I just talked to her", continued to yell with same statements. 4) 6/6/22 at 9:21 p.m., staff noted R1 was very restless, kept trying to get out the doors, following staff and kept trying to find a door he could open. Staff would continue to monitor. 5) 6/9/22 at 9:37 p.m. R1 had been noted to be restless "stopping everyone who passes by" stating he was waiting to go home. R1 became "easily annoyed" when staff attempted to explain he needed to stay. 6) 7/6/22 at 11:43 a.m. R1 was noted as being physically aggressive that day, tried to kick and trip other residents, was hitting staff with cares and had been trying to elope. 7) 7/30/22 at 112:51 p.m. R1 was asking to go	F 689		

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F 689	Continued From page 6 outside and had attempted to go out east door. (That door is an emergency exit which was alarmed). Staff heard the alarm and intervened. 8) 8/21/22 at 2:35 p.m., staff noted R1 was unable to be redirected. Staff noted they "closed the doors so he could not go out". He attempted to open the locked doors and yelled he wanted out. Staff were finally able to convince him to go with staff member to North end by his room. 9) 9/3/22 at 2:23 p.m., staff noted R1 was confused and kept looking for his wife and car. Staff were unable to redirect. 10) 9/6/22 at 1:31 p.m. Resident restless this shift, stating, "Where's my wife?" She's taking me home today. R1 was noted to be "going up and down halls" in his w/c. Review of the progress notes identified R1 demonstrated exit seeking behavior beginning 4/15/22, but there was no comprehensive assessment, safety measures implemented, or a care plan updated until after the September 23, 2022, elopement incident. Interview on 9/28/22 at 11:27 a.m., with NA-A who reported she was in the office behind the receptionist desk when an unknown visitor rushed to the reception desk stating a nurse was needed outside right away. NA-A reported she had run outside and observed R1 lying on his side on the driveway with his w/c tipped on its side. When she approached R1, he was laughing and commented his wife would need to be told about this incident. NA-A reported R1 was attempting to get up and stated he needed help to get out of this situation. NA-B, the Chaplin and administrator had also responded and assisted R1 to stand and sit back in his w/c. A small amount of blood was noted on R1's right elbow,	F 689		

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F 689	Continued From page 7 but he had on a long sleeve shirt, so the injury was not visible. R1 also had a scrape on his right knee that was observed as his pant leg was pulled up. The unidentified visitors left when staff arrived to assist R1, and NA-A reported she was not aware of their identity. R1 was transported to the 200-wing nursing station for assessment by registered nurse (RN)-A. NA-A revealed she was unsure how long it would have been before anyone would have noticed R1 was missing if he had not fallen and a visitor had not seen him. NA-A reported following the incident she had asked trained medication aide (TMA)-A if she was aware R1 had gone out the front doors and fallen and she was not aware he was gone. NA-A reported she was aware R1 had attempted to exit the building previously, and nursing staff had been alerted, but didn't recall when it had occurred or that any interventions that had been put into place. NA-A reported the application of the wander guard after the most recent incident was the first that any intervention had been put into place. NA-A reported she had received annual education on dementia, elopement, vulnerable adults, and reporting, but there had not been any review of policies or education provided following the incident with R1 on 9/23/22. Interview on 9/28/22 at 1:00 p.m. with TMA-A identified she had been working on 9/23/22 and was not aware R1 had exited the building until she had been informed when he was brought back inside, and a wander guard device was applied to his w/c. TMA-A reported R1 wandered through out the facility, and she was not always aware of where he was located. On 9/23/22 TMA-A reported she had been assisting with resident cares and thought it had been at least 20 minutes since she had last seen R1. She	F 689		

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F 689	Continued From page 8 reported that when R1 was not seen for 15-20 minutes staff would usually go check to on his location, but she reported there were no scheduled safety checks or documentation to confirm checks had been completed. TMA-A reported R1 did have a history of wandering and would have verbal and physical behaviors toward others, but it was usually toward staff and staff redirected him if the behavior was toward another resident. TMA-A reported she was not aware if the care plan had interventions in place for R1's behaviors and safety and she would have to go and look. Interview on 9/28/22 at 12:29 p.m., with RN-A reported R1 was confused, wandered through out the facility looking for his wife, and stated his wife was coming to get him. She revealed staff were aware R1 wandered and liked to sit in the front lobby area, but she was not aware of any attempted exits from the facility. RN-A reported elopement assessments were supposed to be completed at the time of admission, quarterly and if there was a change in condition. She reported R1 did not receive an elopement assessment until following the incident on 9/23/22 and confirmed one should have been completed with the 6/2/22 quarterly assessment when his wandering behavior had been identified. RN-A also identified the care plan had not been updated to include R1's behaviors, wandering and and lack of safety awareness due to his severe cognitive impairment. RN-A confirmed the facility policy had not been followed for the completion of elopement assessments, his care plan had not been updated and that there had not been review of the policy or education provided to staff following the incident on 9/23/22.	F 689		

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F 689	Continued From page 9 Interview on 9/29/22 at 10:50 a.m., with activity assistant (AA)-A reported R1 wandered frequently as he looked for his wife and would wheel self toward the doors, stating he needed to go home. She reported R1 was usually able to be redirected, but at times was difficult, insisting he was going home or going to get his car. Interview on 9/29/22 at 12:59 p.m., with the interim medical director identified his expectation for the facility was to complete elopement and fall assessments according to facility policies. If a concern was identified the facility should have implemented interventions to monitor and keep the resident safe. He identified it was concerning that R1 had been able to exit the facility and staff were not aware he was missing until he had fallen, and visitors returned to the facility to notify staff. He agreed the facility had failed to provide adequate supervision of R1 if he was able to exit through the main entrance without staff knowledge. Interview on 9/29/22 at 1:17 p.m., with RN-B identified on 8/21/22 she had been working on the South (200 wing) when R1 became agitated and was not able to be redirected from going to the front entry to wait for his wife. RN-B reported there was not staff in the entry area on weekends and as a safety measure she had closed the fire doors and R1 was not able to open them to access the area. RN-B reported R1 was usually able to be redirected but at times he became agitated and was difficult to redirect. RN-B reported R1 liked to go to the front lobby where he would visit with staff and visitors/residents, watch birds and TV, or sit and watch outside. RN-B reported R1's wandering behavior had initially been identified in the June 2022 quarterly	F 689		

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F 689	Continued From page 10 assessment and an elopement assessment should have been completed in addition to the care plan updated at that time. Interview on 9/29/22 at 2:00 p.m., with the director of nursing (DON) and administrator identified their expectation for staff to follow the facility policy for completion of elopement and fall assessments with the care plan updated to reflect the areas of concern. They confirmed the policy had not been followed regarding completion of assessments, updating of the care plan and provision of education for review of the facility policy/procedure following the incident on 9/23/22. They further reported an elopement assessment including updating of the care plan should have been completed when elopement intent was identified in the June quarterly assessment. Review of the 1/12/22 policy Elopement-Rehab/Skilled: Identified all residents were to be assessed for the risk of elopement at the time of admission and with quarterly, annual, and significant change MDS assessments. The purpose was to identify residents at risk for elopement, have monitoring measures in place, and provide individualized interventions. The assessment was also to be completed as needed when an elopement risk was identified, and investigation completed to identify causes of elopement attempts with individualized interventions implemented. The IJ was removed on 9/30/22 at 3:20 p.m., when it could be verified by observation, staff interviews, and document review, the facility had reassessed R1 and all 9 other residents at risk for elopement. Interventions were developed and	F 689		

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F 689	Continued From page 11 implemented, and staff were educated to those interventions.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: Surveyor: 34083 On 9/28/22, 9/29/22 and 9/30/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please	2 000		

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2 000	Continued From page 1 indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H55584821C (MN87077), with a licensing order issued at 0235. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 235	MN Rule 4658.0065 Subp. 2 Resident Safety and Disaster Planning Subp. 2. Security of physical plant. A nursing home must have a method of ensuring the security of exit doors leading directly to the outside which are not under direct observation from the nurses' station. This MN Requirement is not met as evidenced by: Surveyor: 34083 Based on interview and document review, the facility failed to ensure comprehensive assessments were completed and interventions implemented for 1 of 3 residents (R1) who eloped from the facility into an unsafe area. This failure resulted in an immediate jeopardy (IJ) when R1 left through the facility's front door on 9/23/22 without staff knowledge, tipped his wheelchair off the curb and fell on his side onto the driveway. R1 sustained a minor injury of a scraped right knee and skin tear to his right elbow. Findings include: Review of the 9/23/22 at 2:42 p.m., State Agency (SA) Report identified R1 went out the front entry door onto the sidewalk in his w/c where 2	2 235	Good Samaritan Society-Windom Plan of Correction Sept 28-30, 2022 Survey What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice Immediately after the incident on Sept.23, 2022, R1 was brought to his station by the nursing assistants where a Wanderguard pendant was applied. At the same time, an elopement assessment was completed for R1 with care plan interventions added. A comprehensive assessment, including an elopement assessment and a root cause WHY analysis was completed for R1 on Sept. 29, 2022, with additional	10/6/22

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2 235	Continued From page 3 unidentified visitors observed R1 fall to the side in his w/c and notified facility staff. Staff immediately responded and R1 was discovered to have received a scrapped right knee and skin tear on his right elbow. R1 reported he wanted to see his wife when asked where he had been going. A wander guard device was placed on R1's w/c upon his return to the facility. Review of the 9/28/22 at 6:54 p.m., 5-day SA report identified 9/23/22 as the first time R1 had attempted to leave the facility. R1 was able to move independently in his w/c and his normal pattern was to wheel around the facility many times during the day. It was reported R1 wheeled himself in the main hallways and sat in the reception area by the main entrance to visit with staff, watch the birds or take a nap. The report identified he often spoke of his wife but had not made any attempt to leave the facility to find her. Unidentified staff reported R1 had been observed passing by in the hall four times that morning and he had reported he was "looking for his wife to visit". Unidentified staff attempted to redirect R1, and he had replied, "I think she is coming back". There was no mention staff identified R1 required increased supervision to prevent his elopement out through the front door. Observation on 9/28/22, of the main entrance of the facility identified the main entrance door was covered with an overhang and the drive way curved to allow motor vehicles access to pick up and drop off residents in front of the entrance doors. To the left of the doors the sidewalk curved along the drive and immediately began sloping down out of the parking area to the street which had a steep decline that formed a T with a guardrail at the bottom of the slope. A steep hill was on the other side of the guardrail and	2 235	interventions identified and care planned. Potential root causes identified include: Alzheimer's Disease, Depression, and Loneliness. The following approaches will be reviewed and trialed for success. New Approaches: • Provide all meals in the smaller, quiet, north dining room (closer to his room) • Approach resident in calm manner, with positive facial expressions and pleasant voice • Consult with spouse about resident not having a roommate • Offer resident opportunity to call his wife daily and as needed • Allow resident to awake naturally in the morning • Ensure all staff are aware resident is at high risk for elopement • When exit seeking behaviors are exhibited, provide 1 to 1 monitoring How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the same deficient practice. All residents' assessments were reviewed and as a result, 9 additional residents (R2-R10) were identified as at potential risk for similar deficient practice based on elopement seeking or wandering patterns of behavior. These residents have had a comprehensive assessment, including elopement, completed with care plans reviewed and updated as needed. What measures will be put in place or	

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2 235	Continued From page 4 dropped steeply to the river at the base of the hill. Had R1 not tipped over in his wheelchair, he could have reached the road, with the potential of his chair picking up speed on the slope and possible crashing into the guard rail and been injured or been thrown over the rail and down the steep hill. The main entrance area has the potential for heavy traffic which increased the risk for serious injury if a resident were to exit in front of an incoming or exiting vehicle. Review of video footage of the elopement on 9/23/22 with review beginning at 12:56 p.m. identified: 1) Camera #1 showed R1 propelling himself in his w/c past the unoccupied receptionist desk towards the front door. He stopped just shy of the door and appeared to watch an unidentified person enter and walk past him. At 12:57 p.m. R1 proceeded to the door, pushed open the first door into the entry, and proceeded to push open and exit the outer door onto the sidewalk area. He turned his chair to the left and went out of camera range. Staff and visitors were observed walking in the area, but no one indicated they were aware R1 had exited the building. At 12:59 p.m., a female visitor quickly entered through the doors and went to the reception area where she called for assistance. A second unidentified person entered through the main doors and went down the administrative hall to summon assistance. At 12:59 p.m. Nursing assistants (NA)-A and B were observed running from the office behind the reception desk and out the main door. Immediately following the administrator and Chaplin were observed responding to the summons and they exited out the front door. At 1:01 p.m., nurse aide (NA)-A was observed transporting R1 back into the building in his w/c	2 235	what systemic changes will you make to ensure that the deficient practice does not recur. Organization's policy on comprehensive assessments and elopement has been reviewed and is current. All licensed staff have been educated on assessments and elopement care planning interventions. A licensed staff who completes a mood and behavior note regarding wandering or elopement seeking behaviors will review the resident's current plan to assess for an elopement focus. If there is one, they will review and update interventions as appropriate. If there is not an elopement focus, they will complete an elopement assessment. Additionally, this nurse will notify the Social Worker or Case Manager that they have completed an Elopement Assessment. All employees will receive education in one of 2 methods: Attend a group learning session on Sept. 30, 2022 at 10am or 11am or will receive personal education prior to their next shift. The education topics include: • Review of our elopement policy • Elopement UDA for licensed staff • Assessments of elopement for licensed staff • Identification of change in condition • Reporting elopement behaviors • Elopement care plan interventions Education provided by: GSS LEAD staff on Sept. 30, 2022 and facility charge nurses for those unable to attend the scheduled learning sessions. All exit doors from the facility were	

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2 235	Continued From page 5 and proceeded down the hall toward the 200-wing nursing station. 2) Camera #2 revealed at 12:58 p.m., R1 exited onto the sidewalk outside the main door, turned his w/c left (toward the driveway with the steep incline), appeared get his w/c wheel stuck on the curb and had some difficulty getting it loose and then R1 self-propelled out of camera view. At 1:01 p.m. R1 was transported back into building seated in his w/c by NA-A. R1's 6/2/22, quarterly Minimum Data Set (MDS) identified he had severe cognitive impairment and wandered. This continued in the 9/9/22, quarterly assessment which further identified he required extensive assistance of 1 staff for all activities of daily living (ADLs). R1 had identified behaviors of verbal and physical behavior directed toward others, wandering, and refusal of care. R1's diagnoses included progressive neurological conditions, Alzheimer's disease, and depression. Review of the medical record identified R1 had been admitted to the facility on 12/9/2019, but no elopement assessment was completed until following the incident on 9/23/22. Review of R1's undated care plan failed to identify R1's behaviors of physical and verbal agitation, wandering through out the facility, and his lack of safety awareness with interventions to address the areas of concern due to his severe cognitive impairment. R1's progress notes revealed: 1) 4/15/22 at 3:56 p.m., R1 told staff, "my wife Judy is coming to take me out for dinner". He attempted to leave by the front door. Staff returned him to the North end and provided	2 235	evaluated for security. Only 2 doors were assessed to need additional security. The first was a kitchen door used only for deliveries, is deep into the kitchen, and was kept locked. A double-sided, punch pad door handle was added for extra security on Oct. 6, 2022 by the Maintenance Mechanic. The second door is a not-for-exit door that is kept locked as well, however an alarm box was added on Oct. 3, 2022, by the Maintenance Mechanic, for additional security. The WanderGuard system bracelets on the residents continue to be checked daily and documented in the MAR, along with the door alarms being checked weekly and documented in the TELS Preventative Maintenance system. All exit doors, except the main entry door and back service door, are kept permanently locked. The main door and service door have the WanderGuard alarm system on them and the main door is locked during off hours. The exit doors are audited each shift to assure they are secured and alarmed. Any issues are corrected immediately and/or reported to the Maintenance Department, if needed. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The following audits will be conducted by the QAPI Coordinator or designee, weekly on a sample of residents for 13 weeks with the RAI process providing the resident sample.	

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2 235	Continued From page 6 reassurance he was to have his meal at the facility. 2) 4/27/22 at 1:44 p.m., R1 was noted to be upset, stating "I don't know where [spouse] is...she is taking me home today". R1 was then noting to be "wheeling himself up and down halls on North end of building". 3) 6/4/22 at 1:19 p.m. R1 became upset and wheeled himself to center desk asking, "Where's my wife?" Was told by staff she was not there right now and became upset yelling, "don't' lie to me" I know she is here, I just talked to her", continued to yell with same statements. 4) 6/6/22 at 9:21 p.m., staff noted R1 was very restless, kept trying to get out the doors, following staff and kept trying to find a door he could open. Staff would continue to monitor. 5) 6/9/22 at 9:37 p.m. R1 had been noted to be restless "stopping everyone who passes by" stating he was waiting to go home. R1 became "easily annoyed" when staff attempted to explain he needed to stay. 6) 7/6/22 at 11:43 a.m. R1 was noted as being physically aggressive that day, tried to kick and trip other residents, was hitting staff with cares and had been trying to elope. 7) 7/30/22 at 112:51 p.m. R1 was asking to go outside and had attempted to go out east door. (That door is an emergency exit which was alarmed). Staff heard the alarm and intervened. 8) 8/21/22 at 2:35 p.m., staff noted R1 was unable to be redirected. Staff noted they "closed the doors so he could not go out". He attempted to open the locked doors and yelled he wanted out. Staff were finally able to convince him to go with staff member to North end by his room. 9) 9/3/22 at 2:23 p.m., staff noted R1 was confused and kept looking for his wife and car. Staff were unable to redirect. 10) 9/6/22 at 1:31 p.m. Resident restless this	2 235	i. An audit of mood and behavior notes will be completed to identify any unidentified wandering or exit seeking behaviors. ii. An audit of elopement assessment completion will be conducted to assure the elopement assessments are completed in accordance with policy. iii. And audit of the preventative maintenance system for the door systems will be conducted weekly x12 for completion and proper follow-up for any issues found. Findings will be shared with the QAPI committee monthly x4 months for input on the need to increase, decrease or discontinue audits. The date for correction and the title of the person responsible for correction of deficiency. 9/30/22 by DNS or designee for care planning and education items. 10/6/22 by the Maintenance Mechanic for doors system updates.	

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2 235	Continued From page 7 shift, stating, "Where's my wife?" She's taking me home today. R1 was noted to be "going up and down halls" in his w/c. Review of the progress notes identified R1 demonstrated exit seeking behavior beginning 4/15/22, but there was no comprehensive assessment, safety measures implemented, or a care plan updated until after the September 23, 2022, elopement incident. Interview on 9/28/22 at 11:27 a.m., with NA-A who reported she was in the office behind the receptionist desk when an unknown visitor rushed to the reception desk stating a nurse was needed outside right away. NA-A reported she had run outside and observed R1 lying on his side on the driveway with his w/c tipped on its side. When she approached R1, he was laughing and commented his wife would need to be told about this incident. NA-A reported R1 was attempting to get up and stated he needed help to get out of this situation. NA-B, the Chaplin and administrator had also responded and assisted R1 to stand and sit back in his w/c. A small amount of blood was noted on R1's right elbow, but he had on a long sleeve shirt, so the injury was not visible. R1 also had a scrape on his right knee that was observed as his pant leg was pulled up. The unidentified visitors left when staff arrived to assist R1, and NA-A reported she was not aware of their identity. R1 was transported to the 200-wing nursing station for assessment by registered nurse (RN)-A. NA-A revealed she was unsure how long it would have been before anyone would have noticed R1 was missing if he had not fallen and a visitor had not seen him. NA-A reported following the incident she had asked trained medication aide (TMA)-A if she was aware R1 had gone out the front doors and fallen	2 235		

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2 235	Continued From page 8 and she was not aware he was gone. NA-A reported she was aware R1 had attempted to exit the building previously, and nursing staff had been alerted, but didn't recall when it had occurred or that any interventions that had been put into place. NA-A reported the application of the wander guard after the most recent incident was the first that any intervention had been put into place. NA-A reported she had received annual education on dementia, elopement, vulnerable adults, and reporting, but there had not been any review of policies or education provided following the incident with R1 on 9/23/22. Interview on 9/28/22 at 1:00 p.m. with TMA-A identified she had been working on 9/23/22 and was not aware R1 had exited the building until she had been informed when he was brought back inside, and a wander guard device was applied to his w/c. TMA-A reported R1 wandered through out the facility, and she was not always aware of where he was located. On 9/23/22 TMA-A reported she had been assisting with resident cares and thought it had been at least 20 minutes since she had last seen R1. She reported that when R1 was not seen for 15-20 minutes staff would usually go check to on his location, but she reported there were no scheduled safety checks or documentation to confirm checks had been completed. TMA-A reported R1 did have a history of wandering and would have verbal and physical behaviors toward others, but it was usually toward staff and staff redirected him if the behavior was toward another resident. TMA-A reported she was not aware if the care plan had interventions in place for R1's behaviors and safety and she would have to go and look. Interview on 9/28/22 at 12:29 p.m., with RN-A	2 235		

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2 235	Continued From page 9 reported R1 was confused, wandered through out the facility looking for his wife, and stated his wife was coming to get him. She revealed staff were aware R1 wandered and liked to sit in the front lobby area, but she was not aware of any attempted exits from the facility. RN-A reported elopement assessments were supposed to be completed at the time of admission, quarterly and if there was a change in condition. She reported R1 did not receive an elopement assessment until following the incident on 9/23/22 and confirmed one should have been completed with the 6/2/22 quarterly assessment when his wandering behavior had been identified. RN-A also identified the care plan had not been updated to include R1's behaviors, wandering and and lack of safety awareness due to his severe cognitive impairment. RN-A confirmed the facility policy had not been followed for the completion of elopement assessments, his care plan had not been updated and that there had not been review of the policy or education provided to staff following the incident on 9/23/22. Interview on 9/29/22 at 10:50 a.m., with activity assistant (AA)-A reported R1 wandered frequently as he looked for his wife and would wheel self toward the doors, stating he needed to go home. She reported R1 was usually able to be redirected, but at times was difficult, insisting he was going home or going to get his car. Interview on 9/29/22 at 12:59 p.m., with the interim medical director identified his expectation for the facility was to complete elopement and fall assessments according to facility policies. If a concern was identified the facility should have implemented interventions to monitor and keep the resident safe. He identified it was concerning that R1 had been able to exit the facility and staff	2 235		

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2 235	Continued From page 10 were not aware he was missing until he had fallen, and visitors returned to the facility to notify staff. He agreed the facility had failed to provide adequate supervision of R1 if he was able to exit through the main entrance without staff knowledge. Interview on 9/29/22 at 1:17 p.m., with RN-B identified on 8/21/22 she had been working on the South (200 wing) when R1 became agitated and was not able to be redirected from going to the front entry to wait for his wife. RN-B reported there was not staff in the entry area on weekends and as a safety measure she had closed the fire doors and R1 was not able to open them to access the area. RN-B reported R1 was usually able to be redirected but at times he became agitated and was difficult to redirect. RN-B reported R1 liked to go to the front lobby where he would visit with staff and visitors/residents, watch birds and TV, or sit and watch outside. RN-B reported R1's wandering behavior had initially been identified in the June 2022 quarterly assessment and an elopement assessment should have been completed in addition to the care plan updated at that time. Interview on 9/29/22 at 2:00 p.m., with the director of nursing (DON) and administrator identified their expectation for staff to follow the facility policy for completion of elopement and fall assessments with the care plan updated to reflect the areas of concern. They confirmed the policy had not been followed regarding completion of assessments, updating of the care plan and provision of education for review of the facility policy/procedure following the incident on 9/23/22. They further reported an elopement assessment including updating of the care plan should have been completed when elopement	2 235		

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2 235	Continued From page 11 intent was identified in the June quarterly assessment. Review of the 1/12/22 policy Elopement-Rehab/Skilled: Identified all residents were to be assessed for the risk of elopement at the time of admission and with quarterly, annual, and significant change MDS assessments. The purpose was to identify residents at risk for elopement, have monitoring measures in place, and provide individualized interventions. The assessment was also to be completed as needed when an elopement risk was identified, and investigation completed to identify causes of elopement attempts with individualized interventions implemented. SUGGESTED METHOD OF CORRECTION: The administrator or designee could identify any exit doors not directly under supervision and secure them in a method that prevents potential elopement. The administrator or designee could ensure those doors are routinely monitored and have an audible alarm at the nurses station and is in working order. If staff were not present at the nurses station and the alarm is not audible throughout the building, staff should directly monitor the resident. The administrator or designee could ensure policies and the EP plan identify a method of securing these doors when not under direct supervision. The door security could be placed on the preventative maintenance program. Staff could be re-educated to the importance of securing doors and measurable audits could be performed to ensure those doors are routinely supervised or secured. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring.	2 235		

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2 235	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 235		