

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/21/2024
NAME OF PROVIDER OR SUPPLIER  Good Samaritan Society - Algona		STREET ADDRESS, CITY, STATE, ZIP CODE  412 West Kennedy Street Algona, IA 50511	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49056</p> <p>Based on clinical record review, staff interviews and facility policy the facility failed to appropriately implement interventions to protect 1 out of 1 residents (Resident #61) reviewed from personal degradation. The facility reported a census of 63 residents.</p> <p>The facility completed Social Media and HIPPA training on 10/22/24 prior to surveyors entering the facility on 11/18/24. The deficiency F600 sited at a D will be considered past non compliance.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] for Resident #61 showed the Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. The MDS documented diagnoses of Non-Alzheimer ' s Disease, hypertension (high blood pressure), arthritis, hyperlipidemia (a condition where there are high levels of fats or lipids in the blood), and gastroesophageal reflux disease.</p> <p>Review of the facility self report revealed the facility was made aware on 10/22/24 at 11:30 AM, by Staff A, Dietary Manager, reported a video via social media of Staff B, Certified Nursing Assistant (CNA), having a conversation with Resident #61 while she was sitting in her wheelchair in her room. The video was sent to another dietary aid, who reported it to Staff A.</p> <p>Review of the facility investigation self-report incident occurring on 10/22/24 at approximately 9:30 AM - 4:00 PM revealed the following:</p> <p>Interview conducted with Staff A, Dietary Manager, according to her interview and written statement, Staff A stated that Staff C reported to her another staff member was posting videos on social media of herself with a resident. Staff A reported she received the videos through social media, where Staff B was talking to a resident and getting the resident in the video. Staff B was talking about being her friend, pulling her pants up and sitting on her lap. Staff A stated you can clearly see and hear the Resident in the video. I reported the videos to our Administrator.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview conducted with Staff B, CNA according to her interview and written statement, Staff B denied the incident repeatedly and said nothing of this has ever occurred. Staff B was not able to state if anyone else was present in the room. Staff B stated that she is well aware of the social media and Health Insurance Portability and Accountability Act (HIPAA) policies and that staff are not allowed to take videos or pictures without written permission.</p> <p>Interview conducted with Staff C, Dietary Aide, according to her interview and written statement, Staff C stated that she received the video over the weekend. Staff C stated that she sent it to Staff A to report the concern and denies sending it to anyone else. Staff C confirmed that she is aware of the HIPAA and social media policy and that videos and pictures cannot be taken or distributed without written permission of the resident or family.</p> <p>Interview on 11/19/24 at 9:30 AM with Staff A, Dietary Manager, reported to the Administrator on 10/22/24 that Staff C, dietary aide, received a video via social media of Resident #61. Staff A reported that she has the video. Staff A reported she saw the video on 10/22/24 and took it to the Administrator that day. Staff A stated she knows the CNA in the video but doesn't know the person's name. Staff A stated that this had never happened before and she along with all of the staff received education regarding phone use and HIPPA. Staff A reported she doesn't remember if this was reported to her before 10/22/24.</p> <p>Interview on 11/19/24 at 12:18 PM with Staff C, Dietary Aide, stated that she received from a friend who was a previous employee of the facility, a couple of videos. Staff C stated she received two videos/pictures on 10/18/24 and the third picture on 10/24/24. Staff C stated that the video on 10/18/24 were of Resident #61 and the picture was of a resident's feet. Staff C stated when asked if Staff B told her who's feet they were and she stated yes. The other picture Staff C received was one of a catheter bag and stated she didn't know which resident this was. Staff C stated she reported these to Staff D, Cook. Staff C revealed she couldn't remember if she sent them or showed them to Staff D. Staff C stated I went to report these to Staff A. Staff A then showed them to the Administrator. Staff C stated I talked to the Administrator in his office and explained how I received them. Staff C reported that she didn't show the video's to the Administrator. Staff C stated reported them on 10/18/24 to Staff D. Staff A stated they needed proof. Staff C reported that when she received the video and pictures she took them to Staff A. Staff C stated that she didn't report it to the Administrator because she didn't have his number and didn't know how to get in touch with him.</p> <p>Interview on 11/19/24 at 1:53 PM with Staff D, Dietary Cook, reported that Staff C, texted her and told her that Staff B had taken pictures of the residents. Staff D stated that she has not seen the pictures or the videos. Staff D reported she can't remember when Staff C texted her. Staff D stated she thinks it had been over a month ago or month and a half ago that Staff D texted her. Staff D reported she told Staff C needed to report these to Staff A. Staff D reported this to Staff A. Staff D stated she thinks there was a second picture that this CNA posted, but she has never seen any of the pictures. Staff D reported I think Staff C reported it to me because I am a night cook and that I would immediately let Staff A know. Staff D reported that she does not have the text saved.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/21/24 at 12:30 PM with Staff B, CNA, reported that she was in Resident #6' s room waiting for another staff member to come assist her in putting Resident #61 to bed. Staff B stated that Resident #61 was in her wheelchair and dressed. Staff B stated that no one else was in the room with them. Staff B stated that they were having a conversation and thought Resident #61 was being funny and Staff B started recording their conversation. Staff B stated that while she was holding onto her phone she bent down to do something and she didn't realize her phone turned towards Resident #61's face. Staff B stated she didn't realize her face was in the video and didn't think to go back and look at the video before she sent it. Staff B stated she couldn't remember the conversation that went on between her and the Resident. Staff B stated she was just talking with Resident #61 and didn't think she said anything to her. Staff B stated that she was just joking around with her and that they have a close relationship with her and it is normal to talk to her that way. Staff B stated she does not remember the date she took the video and she has not sent any previous videos or pictures. Staff B did admit to sending this video. Staff B stated that she sent this to a previous employee, this previous employee does not know Resident #61. Staff B stated she thought Resident #61 was being funny and this friend had worked at the facility previously and was a CNA. Staff B stated that she did not realize it was a HIPPA violation to record their conversation.</p> <p>Review of the facility provided policy titled Abuse and Neglect-Rehab/Skilled, Therapy and Rehab Policy dated 7/6/23 revealed the following information:</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, location employees, other residents, consultants or volunteers, employees of other agencies serving the resident, family members or legal guardians, friends or other individuals.</p> <p>To ensure that employees are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations in the location.</p> <p>To ensure the location has an effective system in place that, regardless of the source, prevents mistreatment, neglect, exploitation and abuse of residents and misappropriation of their property.</p> <p>To ensure that residents are not subjected to abuse by anyone, including, but not limited to, location employees, other residents, consultants or volunteers, employees of other agencies serving the individual, family members or legal guardians, friends or other individuals.</p> <p>To ensure that all identified incidents of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported and investigated.</p> <p>To ensure a complete review of existing incidents by the investigation team to identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49056</p> <p>Based on clinical record review, staff interviews, and facility record review, the facility failed to report an allegation of abuse within 2 hours to the Iowa Department of Inspections, Appeals and Licensing (DIAL) for 1 of 1 residents reviewed for abuse due to a staff member sending a video via social media with (Resident #61). The staff member was made aware of the allegations of possible abuse on 10/18/24, the Administrator was not made aware until 10/22/24. The staff member reported she did not know how to get a hold of the Administrator to report it. The facility reported a census of 63 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] for Resident #61 showed the Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. The MDS documented diagnoses of Non-Alzheimer's Disease, hypertension (high blood pressure), arthritis, hyperlipidemia (a condition where there are high levels of fats or lipids in the blood), and gastroesophageal reflux disease (a chronic condition that occurs when stomach contents leak back into the esophagus, the tube that carries food from the mouth to the stomach).</p> <p>The Care Plan dated 8/27/24 revealed Resident #61 required a stand pivot for transfers, needed assistance with ambulation, bathing, bed mobility, dressing, grooming and toilet use.</p> <p>The facility self reported on 10/22/24 to DIAL an allegation of abuse involving Resident #61.</p> <p>Interview on 11/19/24 at 9:30 AM with Staff A, Dietary Manager, stated reported to the administrator on 10/22/24 that Staff C, Dietary Aide, received a video via social media of Resident #61. Staff A reported she saw the video on 10/22/24 and took it to the Administrator that day. Staff A stated she knows the Certified Nursing Assistant (CNA) in the video but doesn't know the CNA's name. Staff A stated that this had never happened before. Staff A reported she doesn't remember if this was reported to her before 10/22/24.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/19/24 at 12:18 PM with Staff C, Dietary Aide, stated that she received a couple of videos from a friend who was a previous employee of the facility. Staff C stated she received a video and picture on 10/18/24 at 11:32 PM and the third picture on 10/24/24 at 7:21 PM. Staff C stated that the video on 10/18/24 were of Resident #61 and the picture of a resident's feet with a comment across the picture stating this man is literally dying. Staff C stated that she asked the previous employee if Staff B told her who's feet they were and she stated yes. The other picture Staff C received was one of a catheter bag with a comment the color a resident's piss and stated she didn't know which resident this was. Staff C stated she reported these to Staff D, Cook. Staff C revealed she couldn't remember if she sent them or showed them to Staff D. Staff C stated she went to report these to Staff A. Staff A then showed them to the Administrator. Staff C stated she talked to the Administrator in his office and explained how she received them. Staff C reported that she didn't show the videos to the Administrator. Staff C reported them on 10/18/24 to Staff D. Staff A stated they needed proof. Staff C reported that when she received the video and pictures she took them to Staff A. Staff C stated that she didn't report it to the Administrator because she didn't have his number and didn't know how to get in touch with him.</p> <p>Interview on 11/19/24 at 1:53 PM with Staff D, Dietary Cook, reported that Staff C texted her and told her that Staff B, CNA, had taken pictures of the residents. Staff D stated that she has not seen the pictures or the videos. Staff D reported she can't remember the dates Staff C texted her. Staff D stated she thinks it had been over a month ago or month and a half ago that Staff D texted her. Staff D reported she told Staff C needed to report these to Staff A. Staff D reported this to Staff A. Staff D stated she thinks there was a second picture that this CNA posted, but she has never seen any of the pictures. Staff D reported I think Staff C reported it to me because I am a night cook and that I would immediately let Staff A know. Staff D reported that she does not have the text saved.</p> <p>Interview on 11/21/24 at 12:30 PM with Staff B, CNA, reported that she was in Resident #61's room waiting for another staff member to come assist her in putting Resident #61 to bed. Staff B stated that Resident #61 was in her wheelchair and dressed. Staff B stated that no one else was in the room with them. Staff B stated that they were having a conversation and thought Resident #61 was being funny and Staff B started recording their conversation. Staff B stated that while she was holding onto her phone she bent down to do something and she didn't realize her phone turned towards Resident #61's face. Staff B stated she didn't realize her face was in the video and didn't think to go back and look at the video before she sent it. Staff B stated she couldn't remember the conversation that went on between her and the Resident. Staff B stated she was just talking with Resident #61 and didn't think she said anything to her. Staff B stated that she was just joking around with her and that they have a close relationship with her and it is normal to talk to her that way. Staff B stated she does not remember the date she took the video and she has not sent any previous videos or pictures. Staff B did admit to sending this video. Staff B stated that she sent this to a previous employee, this previous employee does not know Resident #61. Staff B stated she thought Resident #61 was being funny and this friend had worked at the facility previously and was a CNA. Staff B stated that she did not realize it was a HIPPA violation to record their conversation.</p> <p>Interview on 11/25/24 at 11:43 AM with the Administrator stated that he was not aware of the incident before 10/22/24 and his expectation would be to have the staff bring it to him or their supervisor so they can get it reported in a timely manner, in that 2 hour window.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/25/24 at 4:09 PM with Staff A revealed that she did tell Staff D that they would need proof of the video/pictures. Staff A revealed she didn't remember the exact date this was reported to her, but knows it was a couple of days before 10/22/24 when she went to the Administrator.</p> <p>Review of the facility provided policy titled Abuse and Neglect-Rehab/Skilled, Therapy and Rehab Policy dated 7/6/23 revealed the following information:</p> <p>Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the director of nursing services or the supervisor of social services. These designated individuals are delegated the authority by the administrator to:</p> <ol style="list-style-type: none"> <li>1. Intervene in any situation in order to protect residents.</li> <li>2. Remove any individual from the location necessary for the protection of residents or employees, including but not limited to employees, visitors, contractors or family members.</li> <li>3. Call local law enforcement for assistance with interventions necessary for the protection of residents or employees.</li> <li>4. Call 911 for any type of emergency assistance.</li> </ol> <p>The location will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. Results of all investigations will be reported to the administrator or designated representative and to other officials in accordance with state law, including to the state survey and certification agency within five working days of the incident, or sooner as designated by state law. If the alleged or suspected violation is verified, appropriate corrective action will be taken.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056</b></p> <p>Based on clinical record review, policy review, and staff interview, the facility failed to immediately report an allegation of abuse to the Department of Inspection and Appeals and Licensing (DIAL) for personal degradation, and failed to separate the staff member from the resident after the incident for 1 of 1 residents reviewed for an allegation of abuse (Resident #61). The facility reported a census of 63 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] for Resident #61 showed the Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. The MDS documented diagnoses of Non-Alzheimer ' s Disease, hypertension (high blood pressure), arthritis, hyperlipidemia (a condition where there are high levels of fats or lipids in the blood), and gastroesophageal reflux disease (a chronic condition that occurs when stomach contents leak back into the esophagus, the tube that carries food from the mouth to the stomach).</p> <p>The Care Plan dated 8/27/24 revealed Resident #61 required a stand pivot for transfers, needed assistance with ambulation, bathing, bed mobility, dressing, grooming and toilet use.</p> <p>Interview on 11/19/24 at 9:30 AM with Staff A, Dietary Manager, stated reported to the administrator on 10/22/24 that Staff C, dietary aide, received a video via social media of Resident #61. Staff A reported that she has the video. Staff A reported she saw the video on 10/22/24 and took it to the administrator that day. Staff A stated she knows the Certified Nursing Assistant (CNA) in the video but doesn't know the person's name. Staff A stated that this had never happened before. Staff A reported she doesn't remember if this was reported to her before 10/22/24.</p> <p>Interview on 11/19/24 at 12:18 PM with Staff C, Dietary Aide, stated that she received a couple of videos from a friend who was a previous employee of the facility. Staff C stated she received two videos/pictures on 10/18/24 and the third picture on 10/24/24. Staff C stated that the videos on 10/18/24 were of Resident #61 and the picture was of a resident's feet with a comment across the picture stating this man is literally dying. Staff C stated that she asked the previous employee if Staff B told her who's feet they were and she stated yes. The other picture Staff C received was one of a catheter bag with a comment the color a resident's pissand stated she didn't know which resident this was. Staff C stated she reported these to Staff D, Cook. Staff C revealed she couldn't remember if she sent them or showed them to Staff D. Staff C stated she reported these to Staff A. Staff A then showed them to the Administrator. Staff C stated she talked to the Administrator in his office and explained how she received them. Staff C reported that she didn't show the videos to the Administrator. Staff C reported them on 10/18/24 to Staff D. Staff A stated they needed proof. Staff C reported that when she received the video and pictures she took them to Staff A. Staff C stated that she didn't report it to the Administrator because she didn't have his number and didn't know how to get in touch with him.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/19/24 at 1:53 PM with Staff D, Dietary Cook, reported that Staff C texted her and told her that Staff B, Certified Nursing Assistant (CNA), had taken pictures of the residents. Staff D stated that she has not seen the pictures or the videos. Staff D reported she can't remember when Staff C texted her. Staff D stated she thinks it had been over a month ago or month and a half ago that Staff D texted her. Staff D reported she told Staff C she needed to report these to Staff A. Staff D reported this to Staff A. Staff D stated she thinks there was a second picture that the CNA posted, but she has never seen any of the pictures or video. Staff D reported I think Staff C reported it to me because I am a night cook and that I would immediately let Staff A know. Staff D reported that she does not have the text saved.</p> <p>Interview on 11/21/24 at 12:30 PM with Staff B, CNA, reported that she was in Resident #61's room waiting for another staff member to come assist her in putting Resident #61 to bed. Staff B stated that Resident #61 was in her wheelchair and dressed. Staff B stated that no one else was in the room with them. Staff B stated that they were having a conversation and thought Resident #61 was being funny and Staff B started recording their conversation. Staff B stated that while she was holding onto her phone she bent down to do something and she didn't realize her phone turned towards Resident #61's face. Staff B stated she didn't realize her face was in the video and didn't think to go back and look at the video before she sent it. Staff B stated she couldn't remember the conversation that went on between her and the Resident. Staff B stated she was just talking with Resident #61 and didn't think she said anything to her. Staff B stated that she was just joking around with her and that they have a close relationship with her and it is normal to talk to her that way. Staff B stated she does not remember the date she took the video and she has not sent any previous videos or pictures. Staff B did admit to sending this video. Staff B stated that she sent this to a previous employee, this previous employee does not know Resident #61. Staff B stated she thought Resident #61 was being funny and this friend had worked at the facility previously and was a CNA. Staff B stated that she did not realize it was a Health Insurance Portability and Accountability Act (HIPPA) violation to record their conversation.</p> <p>Interview on 11/25/24 at 4:09 PM with Staff A revealed that she did tell Staff D that they would need proof of the video/pictures. Staff A revealed she didn't remember the exact date this was reported to her, but knows it was a couple of days before 10/22/24 when she went to the Administrator.</p> <p>Interview on 11/25/24 at 11:43 AM with the Administrator stated that he was not aware of the incident before 10/22/24 and his expectation would be to have the staff bring it to him or their supervisor so they can get it reported in a timely manner, in that 2 hour window.</p> <p>Review of Staff B's time sheet revealed the following information:</p> <p>On 10/20/24 punch in at 3:57 PM and punch out 10/20/24 at 9:38 PM.</p> <p>On 10/21/24 punch in at 4:05 PM and out for lunch punch 5:50 PM and in punch at 6:22 PM and out on 10/21/24 at 10:04 PM.</p> <p>Review of the facility provided policy titled Abuse and Neglect-Rehab/Skilled, Therapy and Rehab Policy dated 7/6/23 revealed the following information:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. If an employee receives an allegation of abuse, neglect, exploitation or misappropriation of resident property or witnesses suspected abuse, neglect or misappropriation of resident property, the employee will take measures to protect the resident, provided the safety of the employee is not jeopardized. The employee will then report the allegation to a supervisor.</p> <p>2. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause of the injury. The charge nurse also will ensure that any potential for further abuse is eliminated by taking one of the following actions:</p> <p>a. If this is an allegation of employee to resident abuse, the employee will be removed from providing direct care to all residents. Additionally, the employee will be placed on suspension pending the results of the internal investigation. Another employee will be assigned to complete the care of the resident.</p> <p>3. A designated individual will complete the documentation.</p> <p>4. Notification procedures:</p> <p>a. Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator.</p> <p>b. In case of absence of the administrator, follow the chain of command for notification (director of nursing services, social worker,). If the alleged perpetrator is one's supervisor or department manager, notify his or her supervisor. Document this notification in the electronic health record.</p> <p>c. Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency. If applicable, Adult Protective Services will be notified where state law provides for jurisdiction in long-term care centers.</p> <p>i. If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation 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.</p> <p>ii. 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.</p> <p>d. If the designated agency(ies) requests a written report, notify the social worker and administrator.</p> <p>e. Employees will exercise caution when handling evidence that could be used in a criminal investigation. Do not tamper with or destroy anything that may be evidence. Notify law enforcement of the alleged crime and</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/21/2024
NAME OF PROVIDER OR SUPPLIER  Good Samaritan Society - Algona		STREET ADDRESS, CITY, STATE, ZIP CODE  412 West Kennedy Street Algona, IA 50511	

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>protect the crime scene to prevent the destruction or contamination of evidence. Secure the scene until law enforcement arrives.</p> <p>f. Disclosure of the resident's protected health information may need to be recorded for compliance with the HIPAA Privacy Rule. Contact the privacy point of contact for assistance with logging the disclosure.</p> <p>g. Notify the physician and family regarding the facts of the situation. If there is alleged or suspected abuse/neglect or an injury of unknown origin, inform them that an investigation is in progress. Record this notification.</p> <p>h. Immediately contact regional leadership when there is alleged/verified abuse (sexual, physical, neglect) to a resident that requires outside medical treatment, hospitalization or results in death or causes physical harm, pain or mental anguish.</p> <p>5. After the initial documentation of the incident, if there is a need for additional documentation, this will be completed.</p> <p>6. The investigation team (social worker, administrator and director of nursing services) will review all incidents no later than the next working day following the incident.</p>