STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165240	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Waukon	21 East Main Street Waukon, IA 52172

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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, document review, and staff interview, the facility's administrative staff failed to ensure the staff secured all locked exit doors, resulting in 1 of 3 reviewed residents (Resident #1) at risk for elopement exiting the facility without the nursing staff's knowledge. Due to the facility staff's failures, Resident #1 eloped from the building through the maintenance office door without the nursing staff's knowledge and was missing for approximately 45 minutes before the nursing staff realized Resident #1 was missing by locating Resident #1 laying outside on the ground. The facility's administrative staff identified a census of 51 residents at the time of the on-site investigation.The Iowa State Survey Agency (SA) notified the facility's administrative staff that the situation presented an Immediate Jeopardy situation on [DATE] at 6:00 PM. The immediacy began on [DATE]. The facility's administrative staff removed the immediacy on [DATE] when they took the following actions:- The nursing staff monitored Resident #1's location every 15 minutes, starting [DATE]. - All the keypad locks were immediately disabled and locked at all times on [DATE]. The facility changed the maintenance office door keypad lock on [DATE] to a manual lock key system that remained locked at all times. All remaining doors that utilized keypad locks did not have access to an outside door. The remaining doors were assessed for resident safety if they were able to breach the door. Any doors with keypad locks that were identified as needing to be changed from the keypad to a manual lock were changed on [DATE]. - The nursing staff began holding missing resident drills on [DATE].- All staff received education on elopements prior to their next shift, starting on [DATE].- The staff redirected all security cameras to ensure visibility of the exterior doors on [DATE].- The staff held a QA meeting on [DATE] and continued to monitor elopements through the QA process.As a result of the facility staff's actions, the scope and severity lowered from J to D. The SA surveyor verified the implementation of the removal plan occurred prior to the start date of the on-site investigation. The facility identified a census of 51 residents. Findings Include:A care plan identified the following Focus areas:a. Impaired cognitive function/Dementia or impaired thought process. (revised [DATE])b. Impaired visual function related to (r/t) Macular Degeneration evidenced by (e/b) blindness. (revised [DATE])c. An Activities of Daily Living (ADL) self-care performance deficit r/t Macular Degeneration (e/b) a visual deficit. (revised 7.2.25) The Resident ambulated with the assistance of one (1) staff member and a front wheeled walker in his room and hallway.d. A potential for elopement r/t statements of his desire to have returned home and attempted to go outside. (initiated [DATE])e. At risk for falls r/t vision and a history of falls prior to admission (initiated and revised [DATE])f. An actual fall occurred with a minor injury r/t his gait imbalance and poor vision. (revised [DATE])Review of the facility staff's timeline of events on [DATE] included the following: 1 :45 a.m. - Requested to go to bed so a Certified Nursing Assistant (CNA) took the resident to his room. 1 :47 a.m. - The CNA exited the room after assistance to bed. 1 :50 a.m. - The resident exited his room and turned right outside of his room door. 1 :51 a.m. - Ambulated in the hallway past the Director of Nursing Services (DON) office. 1 :52-1:53 a.m. - Ambulated past the Health Information Management (HIM) and education offices. 1 :55-1:58 a.m. - Ambulated through the dining room and exited through the activity room door. 1 :59-2:06 a.m. - Attempted to open each door. 2:06 a.m. - Entered the maintenance office. 2:12 a.m. - Ambulated on the sidewalk outside the maintenance office to the parking lot/dumpster area where the resident remained. 3:03 a.m. - Located by staff in the parking lot by the dumpster. 3:33 a.m. - Director of Nursing Services notified of the resident's unplanned exit 4:45 a.m. - Administrator notified of an unplanned exit. 4:56 a.m. - Maintenance notified of unplanned exit. 5:30 a.m. - Maintenance assessed lock functionality. A Resident Event form indicated, on [DATE] at 3 a.m., that Staff A, Certified Nursing Aide (CNA), found Resident #1 outside the building but still on the facility's grounds. Resident #1 was fully clothed, wearing a t-shirt, zip up sweatshirt, sweatpants, sock, and black tennis shoes. The form also indicated Resident #1 was previously exit seeking.Review of Resident #1's medical record revealed that Staff D, LPN, documented on [DATE] at 3:52 AM, that the prior night around supper time, Resident #1 wheeled himself to the facility's exit doors and was attempting to exit the building, while making statements that Resident #1 wanted to leave the facility.A Witness Statement form signed by Staff A, CNA on [DATE] at 3:49 a.m., included that at 3:03 a.m., she punched out for a break. When outside she heard someone say help. The staff member looked over to the dumpsters and observed the resident as he laid on the ground. The staff member went over and asked him if he was OK and positioned his head on her foot and called the facility for assistance. During an interview [DATE] at 11:19 a.m., Staff A indicated she worked