STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Howard Lake	413 13th Avenue Howard Lake, MN 55349

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40938 Based on interview and document review, the facility failed to ensure an elopement incident was reported to the State Agency (SA) not later than 24 hours for 1 of 1 residents (R32) reviewed for elopement. Findings include: R32's admission Minimum Data Set (MDS) dated [DATE], indicated R32 had severe cognitive impairment and required extensive assistance with cares. R32 had diagnoses which included amputated toes of left foot, peripheral vascular disease, diabetes, and muscle weakness. R32's care plan revised 6/1/24, identified R32 had potential for elopement related to elopement 5/31/24 (completed after the reported incident). R32's progress notes were reviewed and identified the following entries: - 5/31/2024, at 8:10 p.m. assisted with toileting about 7:30 p.m. refused medications and blood sugar check. When staff went to check on resident at about 8:00 p.m. room door did not open. - 5/31/2024, at 8:15 p.m. family updated was refusing medications, door to room wouldn't open and was observed from his window to be covering up with covers in bed. - 5/31/2024, at 9:00 p.m. daughter arrived, resident did not answer family through the door. It was found that the window to room was open, the screen had been cut and resident was not in the room. Family left immediately to look for him while staff called 911. While staff on the phone with 911, family returned to report resident was at home with his family, that someone had given him a ride home from the bowling alley. A Facility Reported incident was submitted to the SA on 6/3/24, at 5:00 p.m. (approximately 68 hours after resident eloped out window) which identified R32 a non-elopement risk resident left the building through window in room. Locked door with cell phone cord and placed pillows in the bed to make it appear he was laying in it. Proceeded to walk to the roadway next to the building, flag down a motorist and got ride to his home. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 1/09/25, at 3:59 p.m. director of nursing (DON) stated R32 was supposed to discharge to home the week before the incident, facility had discharge orders from the provider at that time. Family had convinced him to stay longer. R32 had gone to an appointment the morning of the incident , believed he was going to go home afterward but the family had brought him back to the facility. The nurse went to attempt medication administration again after he had initially refused, was not able to open the door to the room and R32 was not responding to the nurse so she went outside to look through the window observing R32 laying down in bed and covering up. Nurse had called the family for assistance since he was not responding to her, family arrived about 45 minutes later. R32 did not respond to the family who then went to the window discovering the window open and screen cut, resident was no longer in the room. Facility staff called 911 while the family left and located him at his residence in town. the nurse talked to the good samaritan that R32 flagged down, had not felt comfortable with driving him anywhere but someone from the bowling alley had overheard and gave R32 a ride. Was not reported at the time of the incident as did not feel that this was an elopement, had an order the week prior to discharge, he had a destination and arrived to that destination. Family brought him back later that night. Facility policy titles Abuse and Neglect - Rehab/Skilled, Therapy and Rehab revised 7/22/24, indicated 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35992 Based on observation, interview, and document review the facility failed to accurately complete a comprehensive Minimum Data Set (MDS) assessment for 1 of 1 resident, (R23), who was reviewed for dental status Finding include: R23's Admission assessment Minimum Data Set (MDS), dated [DATE], identified R23 had significant cognitive impairment, however, was independent with eating and oral hygiene. The MDS indicated R23 required assistance with dressing, personal grooming (outside of oral hygiene), and required full assistance with mobility. R23's medical diagnoses included a joint replacement, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), multiple sclerosis (MS-a disease process which has been known to cause numbness, weakness, trouble walking, vision changes and other symptoms), anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), atrial fibrillation (an irregular and often very rapid heart rhythm), heart failure (a progressive heart disease that affects pumping action of the heart muscles, which may cause fatigue, shortness of breath.), hypertension (high blood pressure), and end stage renal (kidney) disease. The MDS indicated R23 had no concerns with broken or missing teeth, or abnormal mouth issues and indicated None of the above were present. R23's quarterly MDS assessment of 10/30/24 lacked entry for dental status of R23. A subsequent MDS of 12/18/24 indicated there were no dental concerns identified. R23's care plan, dated 8/8/24, identified R23 experienced a self-care deficit related to hip fracture. The care plan identified R23 had his own teeth, was able to brush his teeth independently once set up, and was able to eat independently. The care plan directed staff to assist in dressing, grooming, mobility, with a goal to improve current level of function. A review of the record lacked indication R23 was missing the upper portion of his teeth on both the upper and lower jaw, with only the lower portion of teeth remained present. On 1/6/25, at 12:59 p.m., R23 was observed in his room following the noon meal. On the tray, it was noted there were two slices of bread with only the outer crusts remaining, with the center absent. R23 was observed to have only partial teeth on the upper and lower jaw. The lower portion of the teeth remained, however, there were no biting surfaces in place, and appeared to be only the pulp and roots remaining. R23 stated he was aware he needed to go to the dentist, although denied pain. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25, at 3:59 p.m., a review was completed with registered nurse (RN)-A of the dental assessments on the MDS' of 8/14/24, 10/30/24, and 12/18/24. RN-A verified the documentation reviewed indicated there were no dental concerns identified. A review of the care plan at this time also lacked any indication of dental concerns. RN-A stated this data is automatically entered from the [NAME] (Nursing Admit Re-Admit Data Collection) form completed form the time of admission. RN-A was requested to evaluate the R23's dental status and follow up after investigation completed. At 5:26 p.m., RN-A identified R23 was noted to have broken/missing teeth in the center of the upper and lower jaw. RN-A stated dental assessments were completed initially upon admission, and quarterly thereafter, and the dental assessments should have reflected the status of the resident. RN-A stated she had conferred with the director of nursing (DON), who had attended the resident care conference on 12/12/24, at which time R23's dental status was reviewed. The notes reflected plans were made for dental status review at a follow up medical appointment on 1/7/25. Although identified at the care conference, this was not reflected in the care plan. RN-A stated with the concern identified, she would anticipate it would have been identified within the care plan. On 1/9/25, at 3:30 p.m., the DON stated it was her expectation for the MDS to accurately reflect the status of the resident. Additionally, DON stated it was her expectation the care plan be reflective of resident status, and direct staff as to resident needs for assistance and care. The facility policy, MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument)-Rehab/Skilled & Therapy and Rehab, last reviewed/revised 8/27/24 was reviewed. The policy identified during the observation period, each team member will review the EMR (electronic medical record) to determine if there is accurate documentation to support coding for the MDS. The policy directs that if, while reviewing the medical record, the time finds conflicting information, a clarifying note was to be written as part of a supportive documentation note. The guidelines indicated the staff were to attempt to conduct interviews with all residents. The facility policy, Denture and Oral Care, Dental Health Assessment, Dental Services, last reviewed and revised on 6/3/24, identified multiple purposes, which included to observe the oral cavity for abnormalities, provide comfort and well-being, and to maintain healthy condition of teeth and oral cavity. The policy outlines dental assessments are conducted upon admission, quarterly, and with the annual MDS, or with any other oral changes. The purpose of these assessment was identified as early identification and evaluation of any dental/oral health problems for treatment by a dentist or other health professional.