

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Albert Lea		STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240th Street Albert Lea, MN 56007	

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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998</p> <p>Based on observations, interviews, and record review the facility failed to protect 2 of 2 female residents (R2, R1) resident's right to be free from sexual abuse and sexually inappropriate behaviors by male resident (R3). This deficient practice resulted in an immediate jeopardy (IJ) for R1 who had severe cognitive impairment and unable to give consent, however, a reasonable person would have experienced severe psychosocial harm-dehumanization, and humiliation as a result of the sexual abuse.</p> <p>The immediate jeopardy (IJ) began on 2/5/25, at approximately 10:00 a.m. when R3 was in the dining room unsupervised and found rubbing R1's breasts who was unable to leave the area on her own. The IJ was identified on 2/11/25, and the administrator was notified of the IJ on 2/11/25, at 6:00 p.m. The facility had implemented immediate corrective action on 2/5/25 to prevent recurrence, so the IJ was issued at past non compliance.</p> <p>Findings include:</p> <p>R3 Admission Record printed 2/10/25, identified diagnoses of dementia, major depressive disorder, and osteoarthritis.</p> <p>R3's admission MDS dated [DATE], indicated R3 had severe cognitive impairment with a behavior of wandering. R3 was independent with bed mobility, transferring, ambulating with a walker.</p> <p>R3's Progress notes indicated the following:</p> <p>Review of R3's progress notes between 1/18/25 through 2/2/25 identified R3 displayed sexually inappropriate behaviors toward staff on 1/18/25, 1/24/25, and daily between 1/26/25 through 2/2/25; some of those days R3 had behaviors more than once. R3's sexual behaviors included, walking out of his room exposing his genitals, attempting to touch female staff inappropriately, and sexual advances and innuendos directed at female staff. Examples included but were not limited to:</p> <p>-1/18/25 at 7:17 a.m. R3 found wandering in the hallway naked during the night shift and gets handsy with CNA (nursing assistant-NA) and asked if she wanted to sit on his lap.</p> <p>-1/24/25 9:00 p.m. R3 was wandering multiple times out of his room during the evening shift. R3 was also very touchy to staff and touching staff's waist and back, trying to touch front of staff.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 245441
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-1/28/25 at 2:16 p.m. R3 wandered out into the hall with his pants down. Staff redirected him and he was reaching out, trying to grab staff inappropriately. 1/29/25 at 5:08 a.m., R3 was making odd noises and wandering this shift, was in the hall with his pants down and asked the NA do you want to touch my butt?</p> <p>-1/30/25 at 5:24 p.m. R3 started to masturbate in the main dining room. Staff escorted R3 back to his room. Progress note at 9:00 p.m. R3 was grabbing at NA's peri area during HS (nighttime) cares.</p> <p>-1/31/25 at 7:04 a.m. R3 wandering in the hallway and stepped into the hallway with his brief and pants down. R3 redirected back to his room. Progress note at 3:47 p.m. R3 had sexual behaviors during the shift. R3 was walking out in the hall and playing with his penis with his pants down, grabbing at staff.</p> <p>-2/1/25 at 9:00 p.m., multiple behaviors this evening shift. R3 wandering multiple times, wandered into (room number identified- another female resident's) room, wandered to station 4 (four), wandered down the hallway multiple times (twice with his brief and pants down). NA reported R3 was grabbing NA's thigh as she assisted back to his room and asked staff if they would (sic) go to bed with him.</p> <p>-2/2/25 at 9:00 p.m., R3 was wandering out of his room this evening shift and grabbing at staff's peri areas when staff assisted him back to his room. Staff asked him to stop, and he stopped.</p> <p>R3's record reviewed between 1/18/25 through 2/2/25 identified a new onset of sexualized inappropriate behaviors towards staff in and outside of public areas. The physician was not notified of the new behavior until 10 days after R3 displayed sexual behaviors. There was no indication a comprehensive assessment that identified female residents may be at risk, along with developing and implementing appropriate measures as a result of R3's sexual behavior. R3's care plan was not updated to identify R3's sexually inappropriate behaviors.</p> <p>A facility reported incident (FRI) submitted to the state Agency (SA) on 2/4/25 at 1:20 p.m., indicated on 2/2/25 at 9:53 p.m., R3 was found lying next to R2 in her bed. R3 may have been attempting to masturbate while in R2's bed.</p> <p>R2's Admission Record printed 2/10/25, identified diagnoses of dementia, Parkinson's disease, anxiety disorder, and epilepsy. R2's MDS dated [DATE] indicated R2 had severe cognitive impairment with no behaviors. R2's vulnerable adult assessment dated [DATE] identified R2 was vulnerable due to her inability to ambulate without a device, unable to report abuse/neglect concerns; confused to person, place and/or time; forgetfulness; varied cognition; high anxiety level; disruptive; and thought or mood disorder that impair judgement.</p> <p>R2's Progress Noted dated 2/2/25 at 9:50 p.m., identifies a resident-to-resident incident report filed on elder, director of nursing informed of the incident, (family member) informed of incident The note indicated R3 was added to the list for physician rounds.</p> <p>R3's progress note dated 2/2/25 at 9:50 p.m., R3 was found lying in R2's bed next to her. Progress note at 9:59 p.m. identified a soft touch call light placed next to R3's right hip as intervention due recent incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During observation and interview on 2/10/25 at 2:40 p.m., R2's room had a mesh banner across the midway of her door. R2 was sitting with her family member watching television in her room. R2 had difficulty completing her thoughts and sentences.</p> <p>During an interview on 2/10/25 at 4:20 p.m., R2's family member (FM)-A indicated the facility had notified her of an incident on 2/2/25 of a man masturbating while in bed with R2. Further indicated R2 would not likely remember what happened and did not want R2's FM-D to know as it would be upsetting to him. FM-A further stated the facility did not reveal who the man was, but the family knew who he was because R3 wandered into R2's room several times while family was visiting, and they would tell him to leave. FM-A stated in R2's diminished confusion, she[R2] may not have really understood what was happening but would have been horrified and felt very violated if someone was in her bed and it was not her husband. FM-A stated R2 was paranoid and would be upset and worry about it and ruminate about it.</p> <p>During an interview on 2/11/25 at 11:50 a.m., licensed practical nurse (LPN)-A indicated she was working the night of 2/2/25 and responded to R2's call light. Further identified when she found R3 laying next to R2 on top of the covers with his pants halfway down and in the process of masturbating. R2 was lying on her side, under the covers with clothing intact and appeared to be sleeping. LPN-A stated R3 bumped the soft touch call light when he got into R2's bed. NA-B removed R3 from R2's room without difficulty and LPN-A observed R2 for any injuries and found none. LPN-A made the proper notifications and implemented soft touch call light next to R3 in bed to alert staff when he got out of the bed. LPN-A stated she was shocked. LPN-A identified R3 to have a history of wandering into other resident's rooms and trying to touch staff's groin and legs. Further stated R3 moved fast so staff checked on him more frequently and put the mesh stop sign banner on R2's doorway and closed her door.</p> <p>R3's progress note dated 2/4/25 at 1:29 p.m. discussed with R3's family member of concerns of recent behaviors and wandering. Will continue to assist R3's family in discharge planning and memory care placement. Progress note at 3:00 p.m. R3 was standing at the doorway of his room with his pants down masturbating. Staff redirected him back to his recliner. R3 was trying to grab at staff.</p> <p>In review of R3's record there was no indication after the incident with R2 that a comprehensive assessment was completed to determine R3's level of supervision to protect other female residents from R3's sexually inappropriate behaviors.</p> <p>R3's behavior care plan last revised on 2/4/25, The care plan included R3 displayed inappropriate sexual advances towards staff related to dementia as evidenced by grabbing at staff's buttocks and breast, verbalizing sexual comments, and exiting room with penis exposed. There was no indication of what level of supervision of R3 was required to protect female residents.</p> <p>Interventions included:</p> <ul style="list-style-type: none"> -contact health care provider to report new behavior and seek input; -consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate, <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-utilize a consistent staff approach; provide involved residents with opportunities for socialization in supervised areas;</p> <p>-attempt non-pharmacological interventions.</p> <p>-provide resident with redirection on inappropriate behavior. Attempt to give resident something to do with hands while completing cares. State to resident your wife, [name of wife], would not appreciate this.</p> <p>-direct resident to private space if masturbating. Provide adult content magazine to encourage resident's self-gratification to occur in resident's room.</p> <p>R3's care plan did not include stop sign as an intervention.</p> <p>R1's Admission Record, printed 2/11/25, identified diagnosis that included dementia, major depressive disorder, and parkinsonism (brain condition that causes slowed movements, stiffness, and tremors). R1's significant change Minimum Data Set (MDS) dated [DATE], identified R1 had severe cognitive impairment with no behaviors. The MDS indicated R1 required staff assistance for activities of daily living. R1's Minnesota Vulnerable Adult assessment dated [DATE], indicates R1's vulnerabilities included inability to ambulate without a device, visual defects, confused to person, place, and/or time; forgetfulness; and thought or mood disorder that impair judgement.</p> <p>A FRI submitted to the SA on 2/5/25 at 12:14 p.m., indicated R3 left his room and went to the dining room station unsupervised where he reached over R1's back and placed his hands under R1's shirt.</p> <p>R1's Progress Notes on 2/5/25 at 5:17 p.m., indicated communication with family regarding incident from today with another resident and he had no concerns/questions. The progress note did not identify what incident occurred or R1's reaction to R3's inappropriate touching.</p> <p>During observation and interview on 2/10/25 at 4:35 p.m., R1 appeared sleeping in her bed and a man who identified himself as R1's family member (FM-B) was sitting in a recliner watching television. FM-B stated the facility made him aware of a man touching R1 where he should not, but hoped R1 did not realize what happened to her. FM-B further indicated he wanted to know who the man was, but the facility would not tell him and stated, it is upsetting, and I do not want to talk about it anymore.</p> <p>During an interview on 2/11/25 at 11:58 a.m., NA-A stated R3 got grabby with the CNA's and indicated after the 2/2/25 incident staff were told to do 15-minute checks on him. NA-A further identified she was working on 2/5/25, and she was walking out of another resident's room and heard R1 saying stop, stop and witnessed R3 standing to the back left side of R1 with his right hand inside her shirt with his hand on R1's breast and had to remove R3's hand from R1's shirt and remove him from the area. NA-A indicated she had seen R3 prior to the incident, it all happened within a 3 minute time span. NA-A stated RN-A immediately notified the SW and DON and R1 told them there was a guy who grabbed her boobs. NA-A identified R3 has had 1:1 staffing since the second incident.</p> <p>R3's progress note dated 2/5/25 at 1:39 p.m. order to send to emergency room (ER) via ambulance for altered mental status-elevated white blood cell count.</p> <p>R3's care plan was revised on 2/5/25 to reflect R3 will have 1:1 with staff.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R3's Emergency Medicine Discharge Instructions dated 2/6/25 at 11:41 a.m., indicated R3 was discharge with the following diagnoses: change in mental status, behavior sexual high-risk heterosexual, and dementia. Discharge orders were for Seroquel (antipsychotic medication) 12.5 mg twice a day and follow patient closely 1:1 [supervision].</p> <p>R3's progress note dated 2/6/25 at 2:01 p.m. R3 returned to facility from ER.</p> <p>During observation and interview on 2/10/25 at 4:55 p.m., R3 was observed sitting in a recliner in his room. R3's door had a mesh stop banner about midway up the door and a staff person sitting just outside the doorway. R3 appeared sleepy and spoke in partial sentences unrelated to the topic of conversation.</p> <p>During an interview on 2/11/25 at 11:45 a.m., R3's family member (FM)-C indicated the facility notified the family of the incident's on 2/2/25 and 2/5/25 with two female residents. FM-C further indicated R3's sexual behaviors just started a few weeks prior to those incidents and felt most of R3's wandering behaviors were because he was looking for a bathroom but was put on medication after the incident on 2/5/25 and has 1:1 staff now. FM-C questioned the level of supervision at the time of the incidents.</p> <p>During an interview on 2/10/25 at 2:45 p.m., registered nurse (RN)-A . R3 had a sudden onset of sexual behaviors that were directed at staff which included exposing himself in shared areas of the facility, attempts at inappropriate touching, and statements were directed at staff. RN-A described the incident on 2/2/25 as R3 was masturbating in R2's bed while R2 in it. After the incident with R2, staff put a mesh stop sign banner on his door to deter R3 from exiting his room without assistance, put a soft touch call light next to him to alert staff when R3 got up, and implemented more frequent checks. RN-A defined more frequent checks as more frequently than hourly. RN-A described R3 as quick and very quiet and should have stand by assistance when walking outside of his room but frequently self-transferred. RN-A stated on 2/5/25 at approximately 10:15 a.m., R3 went underneath the stop sign unwitnessed and went to a shared sitting area where R3 approached R1 from the back. He reached over her back and put his hands down her shirt and touched R1's breasts. The facility then sent R3 to the ER for evaluation and upon R3's return to the facility, 1:1 direct supervision was implemented. The facility had also implemented daily behavior/mood observations of R1 and R2 and both appear at their baseline.</p> <p>During an interview on 2/11/25 at 10:20 a.m., social worker (SW) indicated R3 had advanced dementia and a behavior of wandering, but the sexual behaviors began suddenly. Further indicated the sexual behaviors started as an occasional comment to staff then became more of a daily occurrence then advanced to exposing himself in public areas. The SW further identified they communicated with family and put interventions and scripting (short and simple set of instructions or phrases that automate responses) in place. The SW further identified after the incidents, R1 and R2 were monitored daily for mood and behavior and have not noted any psychosocial changes and R3 received 1:1 staffing at all times.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 2/11/25 at 11:25 a.m., the director of nursing (DON) indicated R3's sexual behaviors prior to 2/2/25 did not affect other residents and did not wander into other resident's rooms. After the 2/2/25 incident when R3 was found in R2's bed, the facility implemented mood monitoring for R2; mesh stop sign banner across R2 and R3's door; soft touch call light by R3, provided R3 with adult content magazines in room, and more frequent checks. The DON defined his expectation of more frequent checks as eyes on [R3] every 15 minutes. The DON stated the interventions appeared to work until they didn't identifying that on 2/5/25, R3 went under the mesh stop banner and nursing assistant (NA)-A heard R1 saying no, don't touch me, he touched my boob, and swatting R3's hands. DON indicated according to staff interviews R3 had been visualized by NA's 5-10 minutes prior to the incident with R1. The DON indicated he was notified immediately. DON directed immediate 1:1 direct supervision staff for R3, physician and family notifications, R3 was transferred to the ED for evaluation.</p> <p>During a follow up interview on 2/11/25 at 4:10 p.m., the DON and SW indicated they were not aware that R3 had a history of wandering into other residents rooms and R2 was supposed to have a mesh stop sign in place prior to the 2/2/25 incident but was not sure if it was up or not. Further identified they wanted to go with the least restrictive intervention as they did not think R3 would like someone watching him all the time. The facility did not do a comprehensive individualized assessment of the interventions that they put in place and did not assess if R3 could remove the Velcro mesh stop sign banner at the doors. The DON verified the point of care documentation did not reflect 15-minute checks until a 15-minute check form for R3 was implement on 2/3/25 at 3:00 p.m. (approximately 17 hours after the 2/2/25 incident) and have continued since then.</p> <p>The facility policy titled, Abuse and Neglect last reviewed/revised 7/22/24, indicated the resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subjected to abuse by anyone, including but not limited to, employees, other residents, consultants or volunteers, employees of other agencies servicing the individual, family members or legal guardians, friends, or other individuals. If it is an allegation of resident-to-resident abuse, the residents will be separated immediately, and both ensured a safe environment.</p> <p>The past noncompliance immediate jeopardy began on 2/5/25. The immediate jeopardy was removed, and the deficient practice corrected by 2/5/25, after the facility implemented a systemic plan that included the following actions:</p> <ul style="list-style-type: none"> - The facility implemented a plan to ensure R3 had direct 1:1 supervision at all times. -All nursing staff were provided with education and expectations pertaining to R3's care plan interventions and supervision. - Audits have been initiated to ensure R3 had direct 1:1 supervision at all times. - Facility updated R1, R2, and R3's care plan and provided education to staff on changes and updates. 		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998</p> <p>Based on interview and document review the facility failed to report an allegation of abuse timely to the State Agency for 1 of 2 residents (R2) reviewed for allegations of abuse.</p> <p>Findings include:</p> <p>A Nursing Home Incident Report (NHIR) submitted to the SA on 2/4/25 at 1:20 p.m., indicated on 2/2/25 at 9:53 p.m., R3 was found lying next to R2 in her bed. R3 may have been attempting to masturbate while in R2's bed. Submitted approximately 40 hours after the alleged incident.</p> <p>R2's Admission Record printed 2/10/25, identified diagnoses of dementia.</p> <p>R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment with no behaviors.</p> <p>R2's Minnesota Vulnerable Adult assessment dated [DATE], indicates R2's vulnerabilities included inability to ambulate without a device and self-propel the wheelchair; unable to report abuse/neglect concerns; confused to person, place and/or time; forgetfulness; varied cognition; high anxiety level; disruptive; and thought or mood disorder that impair judgement.</p> <p>R3 Admission Record printed 2/10/25, identified diagnoses of dementia.</p> <p>R3's admission MDS dated [DATE], indicated R3 had severe cognitive impairment with a behavior of wandering. R3 was independent with bed mobility, transferring, ambulating with a walker.</p> <p>During an interview on 2/11/25 at 11:50 a.m., licensed practical nurse (LPN)-A indicated she was working the night of 2/2/25 and responded to R2's call light at approximately 10:00 p.m. Further identified when she found R3 lying next to R2 on top of the covers with his pants halfway down and in the process of masturbating. R2 was lying on her side, under the covers with clothing intact and appeared to be sleeping. LPN-A notified the DON, family, and provider.</p> <p>Email communication dated 2/12/25 at 6:09 p.m., the administrator identified the facility would normally report alleged abuse without immediate jeopardy within 24 hours but was informed on 2/3/25 that the DON and regional clinical service nurse determined the incident did not need to be reported because there were no signs of willful intent or injury. The administrator then identified after further discussion of the 2/2/25 incident, she instructed the DON to submit a report to the SA and the report was finalized and submitted to the SA on 2/4/25.</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>The facility policy titled, Abuse and Neglect last reviewed/revised 7/22/24, indicated the resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subjected to abuse by anyone, including but not limited to, employees, other residents, consultants or volunteers, employees of other agencies servicing the individual, family members or legal guardians, friends, or other individuals. If it is an allegation of resident-to-resident abuse, the residents will be separated immediately, and both ensured a safe environment. If there is an allegation of abuse, neglect, exploitation or mistreatment of resident property, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made. If there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported not later than 24 hours after the allegation is made.</p>		