Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 20, 2026

Administrator
GOOD SAMARITAN SOCIETY - ALBERT LEA
75507 240TH STREET
ALBERT LEA, MN 56007

RE: CCN:245441
Cycle Start Date: May 13, 2026

Dear Administrator:

On May 13, 2026, a survey was completed at your facility by the Minnesota Department(s) 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

**ELECTRONIC PLAN OF CORRECTION (ePoC)**

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

**Elizabeth Silkey, Regional Operations Supervisor**
**Mankato District Office**
**Health Regulation Division**
**Minnesota Department of Health**
**12 Civic Center Plaza, Suite #2105**
**Mankato, MN 56001**
**Email: elizabeth.silkey@state.mn.us**

**Office: (507) 344-2742 Mobile: (651) 368-3593**

**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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 13, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 13, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated.  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.**

## INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:  https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

**INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245441 | A. BUILDING **01 - ALBERT LEA...** B. WING | **05/12/2026** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN SOCIETY - ALBERT LEA** | **75507 240TH STREET , ALBERT LEA, Minnesota, 56007** |

| (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 |
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| K0000 Bldg. 01 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/12/2026. At the time of this survey, GOOD SAMARITAN SOCIETY – ALBERT LEA was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required.<br><br>Healthcare Fire Inspections<br><br>State Fire Marshal Division<br><br>445 Minnesota St., Suite 145 | K0000 | | 05/28/2026 |

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 reverse for further 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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| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245441 | (X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - ALBERT LEA...** B. WING | (X3) DATE SURVEY COMPLETED **05/12/2026** |
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| K0000 Bldg. 01 | Continued from page 1<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br><br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>The actual or proposed date for completion of the remedy.<br><br>GOOD SAMARITAN SOCIETY - ALBERT LEA is a 1 story building with no basement.<br><br>The building was constructed at 6 different times. The original building was constructed in 1965 and was determined to be of Type II (111) construction. In 1968, an addition was constructed and was determined to be of Type II (111) construction. In 1975 an addition was constructed and was determined to be of Type II (111) construction. In 1980 an addition was constructed and was determined to be of Type II (111) construction. In 1997 an addition was constructed and was determined to be of Type II (111) construction. In 1998 an addition was constructed and was determined to be of Type II (111) construction.<br><br>Because the original building and the 5 additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type II (111). | K0000 | | 05/28/2026 |

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| K0000 Bldg. 01 | Continued from page 2<br><br>The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 80 beds and had a census of 71 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by: | K0000 | | 05/28/2026 |
| K0345 SS = F Bldg. 01 | Fire Alarm System - Testing and Maintenance<br><br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br><br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br><br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 19.3.4.2, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section(s) 10.19, 14.2.1.2, 14.3.1, Table 14.3.1. These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 05/12/2026 between 9:00 AM and 2:00 PM, it was revealed by review of available documentation that no documentation was presented to confirm that semi-annual visual inspection of the fire alarm system is occurring.<br><br>On 05/12/2026 between 9:00 AM and 2:00 PM, it was revealed by review of available documentation that most recent annual vendor inspection ( | K0345 | K3045 Fire Alarm System Testing and Maintenance<br><br>The location will obtain the documentation for the semi-annual fire alarm visual inspection and the repairs to the fire alarm system.<br><br>All documentation for the fire alarm system will be reviewed to ensure NFPA compliance.<br><br>The maintenance team will be trained in the NFPA requirements for the fire alarm system.<br><br>The administrator or designee will do audits of the fire alarm system documentation weekly x 4 monthly x 2. Results of the audits will be reviewed by the QAPI committee.<br><br>Substantial completion will be achieved by 6-30-26. | 06/30/2026 |

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| K0345<br>SS = F<br>Bldg. 01 | Continued from page 3<br>05/28/2025 ) had system deficiencies - no documentation was presented to confirm deficiencies had been corrected.<br><br>An interview with the Maintenance Director verified these deficient findings at the time of discovery. | K0345 | | 06/30/2026 |
| K0353<br>SS = D<br>Bldg. 01 | Sprinkler System - Maintenance and Testing<br><br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br><br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br><br>a) Date sprinkler system last checked<br>_____<br><br>b) Who provided system test<br>_____<br><br>c) Water system supply source<br>_____<br><br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br><br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, 5.2.1.1.2(5). This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 05/12/2026 at 10:30 AM, it was revealed by observation that sprinkler head(s) located in the Kitchen exhibited signs of debris loading. | K0353 | K353 Fire Sprinkler System Inspection Testing and Maintenance.<br><br>The sprinkler heads in the kitchen will be cleaned to prevent debris loading.<br><br>All sprinkler heads will be inspected to ensure debris loading is not present.<br><br>Staff will be trained in the NFPA requirements for sprinkler heads.<br><br>Audits of the sprinkler heads will be completed by the administrator or designee weekly x 4 monthly x2. Results of the audits will be reviewed by the QAPI committee.<br><br>Substantial completion will be achieved by 6-30-26. | 06/30/2026 |

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| K0353 SS = D Bldg. 01 | Continued from page 4<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K0353 | | 06/30/2026 |
| K0355 SS = D Bldg. 01 | Portable Fire Extinguishers<br><br>CFR(s): NFPA 101<br><br>Portable Fire Extinguishers<br><br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br><br>18.3.5.12, 19.3.5.12, NFPA 10<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on a review of available documentation, and staff interview, the facility failed to properly maintain fire extinguisher documentation in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.2.1.2, 7.2.4, 7.3. These deficient findings could have a isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 05/12/2026 between 9:00 AM and 2:00 PM, it was revealed by a review of available documentation that no annual vendor fire extinguisher inspection documentation was available for review.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K0355 | K 355 portable fire extinguishers.<br><br>The fire extinguisher inspection and documentation will be completed and obtained by the location.<br><br>All fire extinguishers will be inspected to ensure NFPA compliance<br><br>The maintenance staff will be trained in the NFPA requirements for fire extinguishers.<br><br>Audits of the fire extinguisher documentation will be completed by the Administrator or designee weekly x 4 monthly x 2. Audits will be reviewed by the QAPI committee.<br><br>Substantial completion will be achieved by 6-30-26. | 06/30/2026 |

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| E0000 | Initial Comments<br><br>On 5/11/26-5/13/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E0000 | | 05/28/2026 |
| F0000 | INITIAL COMMENTS<br><br>On 5/11/26-5/13/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed: H54411857C (iQIES # 2969875). NO deficiencies were cited.<br><br>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.<br><br>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. | F0000 | | 05/28/2026 |
| F0812<br>SS = F | Food Procurement,Store/Prepare/Serve-Sanitary<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br><br>The facility must - | F0812 | F812: Food Procurement, store/Prepare/Prepare-Sanitary<br><br>Food was not dated, stored past seven-day window, pans weren't completely dry before being put away, utensils weren't covered when placed in cart, personal items were stored in food prep area. This had possibility of affecting all 69 residents in the building at the time of the survey. | 06/05/2026 |

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 reverse for further 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.

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| F0812 SS = F | Continued from page 1<br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and document review, the facility failed to ensure food stored in the refrigerators were labeled, dated and discarded properly. In addition, the facility failed to ensure pans were completely dry before storing, utensils were covered or placed in drawers, and personal items from staff were not allowed in the food prep area. These findings had the potential to affect all 69 residents who were served food from the kitchen.<br><br>Findings include:<br><br>During the initial kitchen tour on 5/11/26, commencing at 9:48 a.m., with the manager of nutrition and food services (MNFS)-C, the following observations were made:<br><br>In a walk-in refrigerator, observed opened and dated food stored past the facility seven-day window per their policy, as well as two opened and undated containers:<br><br>Facility-made "strawberry frost" in a hard plastic container with green cover, dated 3/19.<br><br>Chopped red onion in a plastic storage bag, dated 4/25.<br><br>Red grapes in a plastic storage bag, dated 10/14. There had been a cloudy whitish/grayish liquid in bag with the grapes.<br><br>Chef Grade brand hard boiled peeled eggs, 25 | F0812 | Continued from page 1<br><br>All the food that was stored without dates or past the seven-day window was disposed of promptly when it was discovered in the coolers. New portable cabinets were purchased for storing of utensils to ensure that they remained covered. Staff personal items were removed from the kitchen area including staff's personal food items. The pans were rewashed and put away dry according to policy. This was completed prior to survey exit and remains in effect now.<br><br>All residents in the care center have the potential to be affected by the deficient practice. A review of stored items in the kitchen was completed by the manager of the department to ensure that all items were removed to ensure that it met standards and our policies and procedures.<br><br>To ensure systemic changes are sustained an all-staff meeting was held on June 2, 2026. A review of the Date Marking Food and Nutrition Policy was completed to ensure that staff had an understanding of the policy. The policy Food-Supply Storage-Food and Nutrition Services was reviewed with staff. This policy explains that staffs' personal items cannot be in food preparation or food storage areas to ensure that staff had an understanding of this information. The policy on Warewashing-Mechanical and Manual-Food and Nutrition was reviewed to ensure that staff had an understanding of proper washing and drying techniques of pans. There was a question and answer session after the education to ensure that staff understood the education provided. A post test was administered to staff to ensure competency.<br><br>Audits will be completed on food storage, utensil storage, pan storage, and personal items in the kitchen twice a week for four weeks and then once weekly for eight weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained.<br><br>The Food Service Manager or Administrator will ensure that the deficiency is corrected by June 5, 2026 | 06/05/2026 |

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| F0812 SS = F | Continued from page 2<br>pounds, dated 4/21. MNFS-C did not know the manufacturer recommendation for how long the eggs were good after opening. On 5/12/26 at 11:10 a.m., MNFS-C stated the hard-boiled peeled eggs were good for five days after opening.<br><br>Lettuce in a hard plastic container with green cover. No date. Leaves brown.<br><br>Sour cream container, five pounds, undated and approximately one half left.<br><br>A paper sign on the outside of the walk-in refrigerator dated 1/30/25, indicated: "All dated food items must be tossed at the end of 7 days." MNFS-C removed the items from the refrigerator and stated she would discard them, adding foods were to be dated when opened and prepared foods were to be discarded after seven days. MNFS-C confirmed staff date/mark foods when opened with the month and day, and don't include the year.<br><br>In addition, the following observations were made:<br><br>Two stainless steel, rectangular stacked pans, with areas of water on inner surfaces.<br><br>Three containers of utensils were observed on a wire cart, uncovered. Crumbs in one container.<br><br>Personal items belonging to staff on or in food preparation counters/storage areas including cell phone, car keys, pink mini wallet, small bag of chips, plastic water bottles, thermal mug. In addition, a cell phone was observed in a drawer with utensils.<br><br>During interview, MNFS-C was unaware of the wet pans, and stated they should have been completely dry before stacking. MNFS-C was unaware utensils should be in a drawer or covered container. MNFS-C acknowledged the potential for food contamination with findings.<br><br>During an interview on 5/12/26 at 3:06 p.m., MNFS-C stated on Mondays and Thursdays, the two day-shift cooks were responsible for monitoring food in the refrigerators and discarding opened items after seven days.<br><br>During an interview on 5/12/26 at 4:35 p.m., food service assistant (FSA)-A stated her role was to bake desserts, check cooler for adequate foods for the Always Available menu, among other tasks. FSA-A stated personal items such as cell phones, keys, snacks, were not okay to have in the food prep areas – “it’s not appropriate and could lead to | F0812 | | 06/05/2026 |

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| F0812 SS = F | Continued from page 3<br>distractions." FSA-A acknowledged the potential for food contamination too. FSA-A stated MNFS-C had talked to dietary staff about not having personal items in the kitchen.<br><br>During an interview on 5/13/26, at 8:50 a.m., registered nurse (RN)-C who was also the infection preventionist stated there had been no foodborne illnesses.<br><br>During a phone interview on 5/13/26 at 9:16 a.m., registered dietician (RD)-F had not been aware of kitchen survey findings and therefore informed. RD-F stated she conducted monthly audits using forms through Dining RD software. RD-F had noticed staff not dating opened food. RD-F had not specifically noticed open containers of food past the seven-day window, but stated the standard was to remove opened/dated foods in seven days or less. RD-F stated copies of audits had been given to MNFS-C and going forward would work with MNFS-C and the administrator to ensure on-going compliance.<br><br>During an interview on 5/13/26 at 10:27 a.m., the administrator stated she had been made aware of some kitchen finding by MNFS-C. The administrator stated she expected MNFS-C to have oversight over the kitchen and monitor and ensure staff adhered to policies and regulations. The administrator stated they had started audits with the expectation MNFS-C complete them Monday through Friday and the cooks complete them on the weekends.<br><br>Facility Date-Marking Food and Nutrition policy with reviewed/revised date of 4/7/26, indicated the purpose was to provide guidelines for proper date-marking to ensure food was handled and stored safely. Definitions included: Time/Temperature Control for Safety Foods (TCS), meant food that required time/temperature control to limit pathogenic microorganism growth or toxin formation. TCS food that had been opened but remained in storage, must be clearly date-marked when the original container was opened and the date/day by which the food should be consumed or discarded. At no time should a TCS prepared food be held more than seven days in a non-froze state.<br><br>A policy on infection control measures in the kitchen, included personal items of staff was requested, but according to MNFS-C, the facility did not have such policy. | F0812 | | 06/05/2026 |

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| F0676 SS = D | Activities Daily Living (ADLs)/Mntn Abilities<br><br>CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)<br><br>§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:<br><br>§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...<br><br>§483.24(b) Activities of daily living.<br><br>The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:<br><br>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,<br><br>§483.24(b)(2) Mobility-transfer and ambulation, including walking,<br><br>§483.24(b)(3) Elimination-toileting,<br><br>§483.24(b)(4) Dining-eating, including meals and snacks,<br><br>§483.24(b)(5) Communication, including<br><br>(i) Speech,<br><br>(ii) Language,<br><br>(iii) Other functional communication systems.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to ensure services and assistance were provided to preserve independence for 1 of 1 | F0676 | 2567 Received: May 20, 2026<br><br>Good Samaritan Albert Lea, MN<br><br>Team Leaders: Laura Borris, Administrator; Randy Huls, DNS; Jazmin Johnson, QAPI and IP Nurse<br><br>Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.<br><br>F676 Activities Daily Living (ADLs)/Mntn Abilities- Ensure services and assistance were provided to preserve independence for 1 of 1 residents, reviewed for vision and whose vision was highly impaired<br><br>R44 was given a new magnifying glass so they would be able to read more easily. Menus are being printed in larger print for R44 to ensure that they are able to read and make meal selections that reflect what they would like. A request was made for Services for the Blind to visit with R44 to help provide further resources for them. Services for the Blind will visit with R44 on May 29, 2026. The care plan for R44 was updated to reflect new services and aids offered to them.<br><br>All residents have the potential to be affected by the deficient practice. Specifically, residents with diagnosis that increase risk of visual impairment. A review of medical diagnoses was completed on May 18, 2026 and a comprehensive list was made of residents that have a diagnosis that may increase the likelihood of visual impairment. This list was reviewed and a questionnaire was completed with each resident to ensure that they had the resources needed to maintain independence with their visual ability. Items were offered to residents if they had a need for further assistive devices to maintain their ability to read independently. The care center purchased new magnifying glasses of different sizes and shapes to ensure that residents with visual impairments would have access to these items when | 06/05/2026 |

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| F0676 SS = D | Continued from page 5<br>residents (R44), reviewed for vision and whose vision was highly impaired.<br><br>Findings include:<br><br>R44's significant change Minimum Data Set (MDS) assessment, dated 4/16/26, indicated intact cognition, clear speech, was understood and able to understand. R44's vision was highly impaired, indicating he saw large print, but not regular print in newspapers/books. R44 was independent in some activities of daily living and dependent on staff for others. R44 was able to walk short distances such as to the bathroom.<br><br>R44's care plan dated 11/25/25, indicated R44 had impaired visual function related to macular degeneration evidenced by moderately impaired vision. R44 would maintain optimal quality of life within limitations imposed by visual function. R44 was able to see very large print/newspaper headlines with magnifying glass and glasses; provide R44 with both. The care plan did not indicate R44 had blindness in his left eye.<br><br>R44's Optometrist visit note dated 2/16/26, indicated R44 had age-related macular degeneration in right eye and blindness in left eye. Discussed MN (Minnesota) State Services for the Blind and information given.<br><br>R44's Provider visit note dated 4/8/26, indicated R44 had progressive vision loss and was blind in the left eye from a prior injury and had severe macular degeneration in the right eye.<br><br>R44's care conference note dated 4/10/26, in which R44 had not been in attendance, indicated R44 had blurry vision even with magnifying glass.<br><br>Progress note dated 5/12/26 at 12:02 p.m., indicated social worker (SW)-A had met with R44 regarding referral options from optometrist for vision services, R44 had voiced interest in referral to services for the blind and a referral had been made.<br><br>During an interview and observation on 5/11/26 at 11:47 a.m., R44 stated he had vision issues and was blind in his left eye. R44 stated he had macular degeneration in right eye, and cataracts in both eyes. R44 was observed holding two very small magnifying glasses (about 2 inches in diameter) stacked on top of each other, up to his right eye. The menu was touching his nose in order for him to make out one or two words at a time. The menu was a paper sheet 11 inches X 17 inches and included | F0676 | Continued from page 5<br>needed.<br><br>To ensure systemic changes are sustained an all staff meeting was held on June 2, 2026. A review of the Facility Auxiliary Aids for Persons with Disabilities was reviewed so staff had an understanding of offering and providing services for those with visual impairments and other possible disabilities. A question and answer session was held after the education was provided to ensure that staff understood the education provided. A post test was given to staff to ensure competency.<br><br>Audits will be completed to ensure that compliance is sustained. Audits will be conducted twice a week for four weeks and then weekly for eight weeks. Audits will include review of care plan and interventions. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained.<br><br>The Administrator/DON/ or designee will ensure correction is completed by June 5, 2026. | 06/05/2026 |

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| F0676 SS = D | Continued from page 6<br>menus for 7 days/3 meals a day. The font was approximately size 11.<br><br>During an interview on 5/12/26 at 9:07 a.m., nursing assistant (NA)-A stated she had been aware of R44's difficulty seeing and stated staff were supposed to sit down with him and go through the new weekly menu and help him select his meals. NA-A stated staff wrote directly on the menu, kept a copy for R44 and sent a copy to the kitchen. NA-A stated not all staff did this though. NA-A stated nursing and kitchen staff were aware of his visual impairment.<br><br>During an interview on 5/12/26 at 9:12 a.m., R44 was asked if he could read anything on the menu. On the reverse side of the menu was the activity calendar. He would read the word "May" – which was about 72 font and bold, if held up close without a magnifying glass. He could not read anything else without the aid of the small magnifying glasses. R44 stated no one had offered him a larger magnifying glass.<br><br>During an interview on 5/12/26 at 11:02 a.m., cook (C)-A stated she had not been aware R44 had a visual impairment. When informed he did, C-A stated they should be using a divider plate so staff could tell him where his food was positioned. C-A stated she had never seen a paper menu for R44 with changes made to it. During a review of 5 or 6 paper menus modified by residents none were for R44.<br><br>During an interview on 5/12/26 at 11:10 a.m., the manager of nutrition and food services (MNFS)-C stated she had not been aware R44 had visual impairments and did not know what staff were doing to help him select his meals.<br><br>During an interview on 5/12/26 at 11:28 a.m., social worker (SW)-A stated she had not been aware R44 had visual impairments and suggested speaking to R44's nurse manager.<br><br>During an interview on 5/12/26 at 11:36 a.m., registered nurse (RN)-A, who was also a clinical care leader, stated she was aware of R44's visual impairments. RN-A stated R44 used his own magnifying glass to read the print on the menu and to select his meals. RN-A stated she had seen the magnifying glass and agreed it was small. RN-A stated she had not considered providing R44 with a bigger magnifying glass because he had not asked for one, nor had he asked staff for help with his menu. RN-A was not aware that an NA had reported | F0676 | | 06/05/2026 |

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| F0676 SS = D | Continued from page 7<br>she sat down with R44 with a new menu to help him select his meals. RN-A stated R44 had not asked for that. RN-A admitted she had not approached R44 to ask him how staff could be of assistance to him in selecting his meals given he had difficulty reading the menu. RN-A stated she would talk to therapy to ask if they have a larger magnifying glass for R44.<br><br>During an interview and observation at 5/12/26 at 11:55 a.m., SW-A had a magnifying glass, approximately four inches in diameter with a handle and light that she would give R44 to try.<br><br>During an interview on 5/12/26 at 12:08 p.m., in R44's room, he picked up the new magnifying glass to read the menu. Even with the larger magnifying glass, R44 had to hold the menu very close to the magnifying glass in order to read the words. R44 could slowly read one word at a time. R44 stated prior to surveyor asking him if he would like assistance selecting his meals due to his visual impairment, R44 stated no one had ever asked him, nor helped him make meal selections before. R44 stated staff did not come into his room to assist him with meal selections when the new menu came out. R44 stated, "Is that possible?"<br><br>During an interview on 5/12/26 at 5:44 p.m., the director of nursing (DON) stated he had not been aware of R44's visual impairment, adding, "He never came to us and told us." Further, the DON stated, "If staff would have noticed, we would have taken more action." The DON had not been aware macular degeneration and blindness had not been listed on R44's diagnoses list. The DON was informed R44's MDS indicated his vision was "highly impaired", and there were limited interventions on the care plan related to his visual impairment.<br><br>Facility Auxiliary Aids for Persons with Disabilities with reviewed/revised date of 1/15/26, indicated appropriate steps would be taken to ensure persons with disabilities, including persons who were blind or who had other sensory impairments had an equal opportunity. All necessary auxiliary aids and services would be provided without cost. For persons who were blind or who had low vision, staff would communicate information contained in written materials by reading out loud and explaining forms to persons who were blind or who had low vision. Social services was responsible to provide aids and services in a timely manner using qualified readers, reformatting into large print, taping or recording print materials, or other effective methods. Auxiliary aids and services must be provided in accessible formats in a timely manner and in a way that | F0676 | | 06/05/2026 |

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| F0676 SS = D | Continued from page 8 protects the privacy and independence of the individual with the disability. Examples include screen reader software, magnification software. | F0676 | | 06/05/2026 |