



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 18, 2026

Administrator
GOOD SAMARITAN SOCIETY - JACKSON
601 WEST JACKSON
JACKSON, MN 56143

RE: CCN:245455
Cycle Start Date: July 31, 2026

Dear Administrator:

On July 31, 2026, a survey was completed at your facility by the Minnesota Departments 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:

Nicole Dahl, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230

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 October 31, 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 January 31, 2027 (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,



Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



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GOOD SAMARITAN SOCIETY - JACKSON
601 WEST JACKSON
JACKSON, MN 56143

Re: State Nursing Home Licensing Orders
Event ID: 235D57-H1

Dear Administrator:

The above facility survey was completed on July 31, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the

correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Dahl, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245455		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - JACKSON				STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON , JACKSON, Minnesota, 56143			
(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
E0000	Initial Comments On 7/27/26 through 7/31/26, 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. 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			
F0000	INITIAL COMMENTS On 7/27/26 through 7/31/26, a standard recertification survey (S5455041-0) 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. The following complaints were reviewed: H54553457C (2656440) and H54553458C (2655855). NO deficiencies were cited. 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. 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			
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)			F0812			

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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F0812 SS = F	Continued from page 1 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure infection control measures were followed during observation of 1 of 1 meal services. This had the potential to effect all 36 residents in the facility. Findings include: Observation on 7/29/26 at 11:29 a.m. as cook-A completed preparation of the noon meal consisting of chicken with mushroom gravy, noodles, and broccoli. Cook-A was placing the food items onto the steam table when she turned and went to the cabinet, opened the door, removed a saltshaker, and shook salt into her bare hand. After filling the palm of her hand with salt she returned to the stove, where she dumped the salt from her hand into the cooking noodles. When questioned as to her action, she replied she had measured the salt to add to the noodles. She then asked if this was a problem as that was how she always did it. Cook-A then set the pot into the sink and prepared a fresh pot of noodles which were placed onto the steam table. As she was pouring the noodles into the steamtable pan several noodles landed on the counter Infront of the pan. Cook-A used her bare hand and tossed the noodles from the counter back into the pan of			F0812			

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F0812 SS = F	Continued from page 2 noodles in the steamtable. Observation on 7/29/26 at 11:42 a.m. as cook-A washed her hands, returned to the counter across from the steamtable, where she picked up a tray containing 2 paper meal slips, picked up the slips and identified the resident meals, turned back to the steamtable, picked up 2 plates, and began placing food items onto the plates. She used a large, slotted spoon to scoop noodles onto the plates, then placed the slotted spoon on the side of the steamtable, went around the steamtable to a drawer which she opened with her bare hand, removed a green handle scoop spoon and returned to plating the meal. As she was scooping noodles onto the plate, several noodles were hanging off the side of the plate, and she used her bare hand to scoop them back onto the plate. Cook-A placed the filled plates onto the tray and pushed them into the window for staff to serve to residents in the dining room. Cook-A continued the same process of serving several plates and again used her bare hand to scoop noodles hanging off the side of the plate back onto the plate being served. Observation on 7/29/26 at 11:52 a.m. as cook-A left the steamtable, walked into the dining room where she went to trays set-up on a cart, and identified as room trays. She returned to the steamtable with no hand hygiene and continued to plate meals, covered with a lid, and after stacking 4 covered plates, she took them into the dining room and placed them onto the trays designated as room trays. Cook-A then returned to the kitchen, took a cloth from the bucket of sanitizer solution in the sink and began wiping down the counter and cart that had contained the pudding served for dessert. Interview on 7/29/26 at 12:05 p.m. with cook-A reported she had always measured seasonings using her hand and was not aware there was a problem doing it that way. When asked about serving of the noodles and handling them with her bare hands, reported she did not realize she had done that and reported she should have, tossed the noodles that landed on the counter Infront of the steam pan, and used the scoop to position noodles on to plates instead of her hand. Interview on 7/29/26 at 12:15 p.m. with the certified dietary manager (CDM) identified her expectation for infection control practices to be followed in the			F0812			

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F0812 SS = F	Continued from page 3 kitchen. She reported she was not aware cook-A used her bare hand to measure spices, and she should have used measuring spoons, not her hand. Regarding touching food with bare hands was not acceptable practice, and she expected staff to use utensils and appropriate hand hygiene practices. She identified anytime staff left the steam table area; they needed to use hand hygiene before returning to serving food. Interview on 7/29/26 at 1:30 p.m. with the infection preventionist (IP) identified her expectation for all departments to follow appropriate infection control practices by utilizing hand hygiene practices. Review of the 7/14/26, Sandford Policy Food Handling-Food and Nutrition identified prevention of food related illness to a highly susceptible population in the facility. This was identified as the need for handling of food in a manner to decrease the risk of contamination. The procedure identified food items were not to be touched using bare hands. Utensils including tissue, spatulas, tongs and single-use gloves were to be utilized when handling food items. Hand hygiene was identified as washing with soap and water and gloves were to be utilized when indicated due to needing to tough a food item.			F0812			
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to			F0880			

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F0880 SS = F	Continued from page 4 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			F0880			

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F0880 SS = F	Continued from page 5 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to identify when an employee would be able to return to work (RTW) for 3 of 3 sampled staff (nursing assistant (NA)-A, NA-F, and licensed practical nurse (LPN)-A) identified with potential norovirus symptoms. This had the potential to affect all 36 residents residing at the facility. Findings include: Review of the 2024-2025 Norovirus Information for Long-term Care Facilities, located at, https://www.health.state.mn.us/diseases/foodborne/outbreak/facility/lcfnorotoolkit.pdf, identified Norovirus is transmitted through a fecal (stool)-oral route with symptoms of diarrhea, vomiting, nausea, abdominal pain, low grade fever, headache, and or body aches. Individuals generally become ill 12-48 hours after exposure (swallowing Norovirus). Infected individuals shed the virus in their stool and contaminate food, surfaces, and objects and can be shed in the stool for several weeks after recovery. Products used to clean Norovirus must say they are effective against Norovirus. Hand sanitizer does not work to kill the virus. Individuals should wash their hands for 20 seconds with soap and water. Individual cases of Norovirus are not reportable to the State, however, possible outbreaks or multiple cases with Norovirus-like symptoms must be reported. Documentation of possible outbreaks was to include: Use the RESIDENT ILLNESS LOG and STAFF ILLNESS LOG to document illnesses among staff and residents/patients: Contact managers of each unit, etc. as necessary to gather illness information. Send both ILLNESS LOGS back to MDH within 2 business days of reporting the suspected outbreak. Epidemiology staff will use this to assess A) which pathogen is causing the outbreak, B) the likely route of transmission, and C) whether additional prevention measures are needed. Gather additional information List activities, events, etc., held during the week prior to the first illness (especially if food was			F0880			

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F0880 SS = F	Continued from page 6 served). Determine when and where there were any vomiting incidents or diarrheal accidents in the facility. If requested by MDH, provide a dietary menu (breakfast, lunch, and dinner). If requested by MDH, provide names and phone numbers for staff and/or residents (in rare cases, MDH may want to conduct interviews). Collect a stool sample from three (3) residents and/or staff and send to MDH Laboratory for analysis (MDH will provide specimen collection kits; the testing is free of charge). If stools from residents or staff were sent to a clinical laboratory, notify MDH of any results. Send both completed ILLNESS LOGS back to MDH between 1 and 2 weeks after the last illness. IMPLEMENT OUTBREAK CONTROL MEASURES: Monitor for resident illness (record on RESIDENT ILLNESS LOG) and when possible, isolate residents while they are ill and for 72 hours after symptoms have stopped. Consider halting new admissions until the outbreak has ended. Exclude actively ill residents from games/activities where touching common items occurs (e.g., checkers, cards). Monitor for staff illness (record on STAFF ILLNESS LOG) and restrict ill staff/volunteers from patient care and food handling duties until 72 hours after their vomiting/diarrhea has ended. Review of the current, undated Centers for Disease Control (CDC) Norovirus guidelines, located at https://www.cdc.gov/norovirus/index.html, identified Norovirus is a very contagious virus that causes vomiting and diarrhea. It is sometimes called the "stomach flu" or the "stomach bug." However, norovirus illness is not related to the flu. The flu is caused by the influenza virus. Norovirus causes acute gastroenteritis, an inflammation of the stomach or intestines. Most people with norovirus illness get better within 1 to 3 days; but they can still spread the virus for a few days after. Most common symptoms: Diarrhea, vomiting, nausea, stomach pain. Other symptoms: Fever, headache, and body aches. Food workers should stay home when sick and for at least 48 hours after symptoms stop. This also applies to sick workers in schools, daycares, healthcare facilities, and other places			F0880			

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F0880 SS = F	Continued from page 7 where they may expose people to norovirus. Review of Employee Illness Tracking log included a section to log the employee's name, the unit they worked on, the date of the call in, the illness symptoms, the onset date, prevention measures (work restriction, COVID testing, etc.) and the return-to-work date. Review of the April, May, and June 2026 Employee Illness Tracking logs identified the following: NA-A called in on 4/2/26, with symptoms of diarrhea, the onset was 4/2/26 and noted in the prevention measures section of the form identified removed from work. The return-to-work date was left blank. Review of NA-A time punch for that week identified NA-A returned to work on 4/4/26. NA-F had called in on 4/7/26 and 4/8/26, with symptoms of fever and diarrhea, the onset was 4/7/26 and noted in the prevention measures section of the form identified removed from work. The return-to-work date was left blank. Review of NA-F time punch for that week identified NA-F returned to work on 4/9/26. LPN-A had called in on 6/18/26, with symptoms of vomiting and diarrhea, the onset was 6/18/26 and noted in the prevention measures section of the form identified removed from work. The return-to-work date identified LPN-A return to work on 6/19/26. During interview on 7/30/26 at 4:00 p.m., with registered nurse (RN)-C who was the infection preventionist, agreed that the Employee Illness forms for April and May 2026, were not filled out thoroughly and lacked identification of a return to work. She stated she did not track when employees returned to work very well. The June 2026 Employee Illness form was completed thoroughly and identified the return-to-work date. RN-C confirmed that NA-A, NA-F, and LPN-A had returned to work too soon according the MDH Norovirus employee return to work guidance for potential norovirus however, she did not believe that any of the employees were suspicious of having norovirus. Interview on 7/30/26 at 11:30 a.m., with the regional clinical services director identified the facility should be documenting and filling out the employee illness form thoroughly. She agreed the facility should			F0880			

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F0607 SS = E	Continued from page 9 §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to follow facility policy to identify allegations of verbal abuse and threats of involuntary seclusion reported through grievances, that were made about 2 staff (registered nurse (RN)-A) and licensed practical nurse (LPN)-A) involving 6 of 40 residents (R27, R30, R43, R13, R44 and R100). In addition, the facility also failed to perform timely and thorough investigations, report allegations to the SA, and immediately suspend RN-A and LPN-A per policy pending the investigations. Findings include: Review of the grievances submitted from 2025 and 2026 grievances identified the following grievances: On 8/19/25, a grievance was filed regarding R100 by the former director of nursing (DON)-A. R100 reported LPN-A was rude to R100 on or about 8/5/25. R100 was “very agitated” when he was discussing his concerns to the reporter and could not describe anything specific that LPN-A said, however felt it was much more her “tone and how she said things” to him. R100 reported LPN-A was like “Sergeant Slaughter” (a professional wrestler who dressed as a military drill sergeant and known to be very harsh in behavior) and was “very stern...do as I say” person. “She just wasn’t talking nice to me”. An interview occurred with an unknown party (U)-A. R100 had called her because he was upset. He was upset about the chair and that he could not get a sleeping pill. R100 reported “this place is terrible”. U-A could not calm R100 down because he was so upset. U-A also called to speak with LPN-A. LPN-A explained R100 shouldn’t be getting up on his own and that staff would assist him. LPN-A also reported to U-A that the facility couldn’t start a sleeping pill without doing a sleep study. U-A reported she became upset with LPN-A when LPN-A had asked her if R100 had ever been married. U-A stated “no”. LPN-A said “well he must not be able to handle women well... well, you know how these old farmers are”. There was no more information provided from the interview. LPN-A was			F0607			

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F0607 SS = E	Continued from page 10 then interviewed and remarked she had asked U-A if R100 had ever been married and stated she had commented “well, maybe he just doesn’t take direction well from women”. The reported explained comments like that “came across” as unprofessional and should be avoided in the future. LPN-A admitted it wasn’t the best “word choice” but had not intended to be disrespectful or rude. LPN-A was told to “reflect on this situation and choose her words more carefully in the future”. The resolution was education had been given to LPN-A ensuring professional conversation was maintained when communicating with residents. The DON signed off on the report on 8/19/25, however, the administrator had not signed off the report until 3/5/26. No other residents and/or representatives were interviewed, nor were any other staff members interviewed. There was also no follow up noted to determine if R100 was asked if they felt safe or if there had been any effects on R100’s psychosocial or physical status with lack of a potential sleep aide that may have been able to be offered, or if R100 had any psychosocial outcome such as increased behaviors, or further instances from LPN-A with other comments etc. No other staff or residents were identified to have been interviewed to determine if similar incidents had occurred with other residents. On 11/10/25, registered nurse (RN)-B made a grievance report on behalf of R30 to DON-A, (2 days later) that on 11/8/26. R30 had reported that she heard RN-A yelling loudly at R44. RN-A then entered R30’s room and told R30 “I don’t care if he is your friend... I don’t like him; he’s not a good patient”. The facility interviewed RN-B and she reported the order of events were that R30 had told her RN-A was yelling “so loud that the building could hear”. R30 did not know specifically what RN-A had said to R44. R30 had also reported that RN-A entered her room and stated “I don’t care if he’s your friend. I don’t like him he’s not a good patient”. R30 also told several people she hoped RN-A did not treat them like that. DON-A directed RN-B to speak to R44 to see if he felt safe and ask how staff treated him. RN-B followed up with DON that R44 responded he felt safe and stated, “I don’t like being here but they’re all treating me good”. An interview with RN-A identified she denied yelling at R44. She reported she was just reminding him that he needed to ask for help. R44 was saying he was being “imprisoned” and kept getting up on his own. He also threatened to pull the fire alarm. RN-A reported R44 was basically a 1:1 due to behaviors and continual attempts to transfer. R30 was interviewed and stated she had no concerns about how RN-A treated her. DON-A had a conversation			F0607			

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F0607 SS = E	Continued from page 11 with RN-A to which RN-A denied yelling at R44 and only tried to redirect him. There was no mention the facility asked RN-A if she had spoken to R30 as noted above in the grievance as no other areas of the concern were documented. There was also no mention the facility identified the yelling would be considered an allegation of verbal abuse and should have been reported to the State agency (SA) and administrator immediately on 11/8/26, vs 2 days later on 11/10/26, and re-educated staff to what verbal abuse was, or ensured staff were timely reporting to the administrator and SA. There was also no mention the facility had interviewed other residents and/or their representatives other than R30 and R44, if they interviewed other staff, or had placed RN-A on suspension pending an investigation. The administrator signed off on the report on 11/10/25. On 11/17/25, R27 reported a concern to the administrator about RN-A was treating her. R27 reported RN-A had told her she was “going in a time-out”. R27 asked why and RN-A told her “because you don’t know what you are doing”. R27 stated this made her feel “inadequate”. It was also noted the incident occurred on 11/15/25 or 11/16/25. The investigation identified an interview was conducted with nursing assistant (NA)-A who stated “I just want to start with and say that the day I worked with RN-A and NA-C on north, was one of the best days I worked on north. Things went smoothly”. When asked about general concerns regarding RN-A, NA-A stated, “she is assertive and bossy” and gave a random example of a resident (R43) who would go into their room in a wheelchair and staff may say to RN-A “oh they just went to their room”, and she “will drag them back out”. NA-A reported RN-A made R43 very upset that day (unknown date), and he was “snappy” because of how RN-A treated him and “he is never that way”. R43 normally would go into his room, and staff just paid attention to him if he tried to get up to go to the bathroom. NA-A further reported RN-A was also noted to be standing in front of his room blocking him from entering and said, “You can’t go in... staff will help you”. NA-A felt RN-A’s approach was the issue as she is “assertive and bossy” with the residents. RN-A was interviewed and a summary of the complaints was read to her. In the summary, it was noted R27 voiced to her family member about RN-A not allowing her into her room. RN-A denied that she yelled at residents. RN-A admitted she did block R43 from going into his room as she “did not want him to fall self-transferring”. When asked why she did not go with R43 to assist him with a transfer verse blocking him, she reported she was “worn			F0607			

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F0607 SS = E	Continued from page 12 out”. RN-A reported she does not “intend to yell” at residents. She acknowledged she may raise her voice, but that was so they could hear her. The DON directed RN-A to reflect on her tone, volume of voice, body language, and word choice. She needed to “soften her tone and approach”. RN-A was tearful reporting that she had been trying hard to change her approach since the last conversation. Attached to the grievance was an email that had been sent to the administrator and DON on 11/16/21 at 11:03 a.m., (the sender of the email had been redacted). The email identified there were a few complaints/concerns regarding RN-A over the weekend (unknown if that was 11/15/25 or 11/16/25 weekend or prior). The email identified on Thursday (presumably 11/13/25) RN-A had “very much upset” R13 and had her “all worked up” as RN-A “yelled” at her for hollering out. Nurse aide (NA)-B had to console R13 as she kept saying “she yelled at me”. The unknown author of the email identified being told by multiple people that RN-A “hollered” at certain residents as they attempted to self-transfer. RN-A would get mad at the residents and scold them for self-transferring. The unknown author identified that NA-A reported RN-A would not let certain residents go back into their room as RN-A stated, “they can’t be in their rooms in a wheelchair” and stating “you can’t be in here” standing in front of R43’s door scolding him and not letting R27 go back to her room and “jumping down [R44’s] throat” when he self-transferred. The unknown author identified R27 was the most upset about this and refused to go to supper because she would “get yelled at”. R44 stated he was “sick of that big lady hollering at him” and apparently R43 was very upset on the day [shift] also. The unknown author reported they had heard on multiple cases of RN-A hollering or scolding residents and “that was not ok, and the residents deserved better than this”. 3 residents were interviewed along with R27. R27 had complaints of treatment and reported RN-A kept saying to her “you’re just going to timeout” and “kept putting her in a timeout”. When R27 asked why, RN-A told R27, “you don’t know what you are doing”. The questions about staff talking respectfully to others and if she felt safe here were blank. The question about who to report to R27 had reported she would talk with her daughter. The other 3 residents felt like they were treated respectfully and had no concerns. None of the interviews were dated when they occurred or identified who asked the questions. The resolution section and follow-up comments on the grievance report were left blank. There was no indication the administrator or DON acted per the facility policy on the alleged allegations of verbal abuse and involuntary, that a			F0607			

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F0607 SS = E	Continued from page 13 formal investigation occurred, nor mention that RN-A had been suspended while the facility investigated the recurring concerns, staff re-educated about reporting or if the facility identified potential burnout by RN-A's comments. The administrator signed off the report on 3/5/26. Interview on 7/29/26 at 3:26 p.m. with regional clinical service director identified the grievance forms were missing information including a thorough investigation of each grievance with follow up to the concerned party. She agreed that the facility should have acted upon that email and the grievances (allegations of verbal abuse and involuntary seclusion) should have resulted in the suspension of RN-A and the administration should have immediately started an investigation. She revealed in all the grievances reviewed from November and December 2025, there seemed to be a pattern of only interviewing the parties identified in the concern and agreed that further interviews should have been completed to ensure a thorough investigation had occurred. She further agreed that the resolution and follow-up with the party concerned was lacking in most of the reviewed grievances and should have been completed per facility policy to ensure a satisfactory resolution. Her expectation was that the facility would brainstorm to ensure all grievances were handled and resolved appropriately. She made no mention the grievances were allegations of verbal abuse and involuntary seclusion and should have been reported to the SA immediately. Interview on 7/30/26 at 8:07 a.m., with the administrator identified he felt the facility did start an investigation. The DON-A was to complete the investigation and that was why he had not participated in it. He reached out to DON-A who reported the concern. DON-A did educate RN-A but did not document that education. The facility completed interviews with residents last night (7/29/26) (nine after the incidents) and suspended RN-A while a new investigation was being conducted. He stated there was no verbal abuse identified and the situation “had been handled” as R27 had no concerns and there had been “no lasting effect, and no signs of psychosocial distress”. The administrator declined to answer if RN-A should have been suspended when the incidents occurred for R30 and R44 in order to potentially prevent further incidents with R27 and other residents.			F0607			

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F0607 SS = E	Continued from page 14 Review of the 4/7/25, Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy and Rehab policy identified the policy was created to ensure employees were knowledgeable regarding the reporting and investigative process of abuse and neglect allegations, and ensure an effective system was in place that prevented mistreatment, neglect and abuse. It was also designed to ensure a complete review by the investigative team was completed to identify allegations of abuse and neglect were promptly reported and investigated. Allegations involving mistreatment, neglect, or abuse were to be reported immediately to the administrator in order to intervene and protect residents. With an allegation of employee to resident abuse, the employee was to be removed from providing direct care to all residents. And be placed on suspension pending the results of the investigation. Allegations were to be reported immediately but no later than 2 hours after the allegation was made. Allegations that did not involve abuse and had no serious bodily injury were to be reported no later than 24 hours after the allegation was made. The investigation team (social worker (SW), DON and administrator) were to review all events no later than the next working day following the event. The facility was to ensure someone was assigned to complete the investigation and the SW or designee was to notify the SA. The investigation was to include interviewing employees, residents and/or witnesses to the event, but made no mention of interviewing others not directly involved but who may have knowledge about other pertinent facts or data of incidents. The SW or designee was to report results of all investigations to the SA within 5 working days of the event.			F0607			
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated			F0610			

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F0610 SS = E	Continued from page 15 representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to identify allegations of verbal abuse and threats of involuntary seclusion reported through grievances, that were made about 2 staff (registered nurse (RN)-A) and licensed practical nurse (LPN)-A) involving 6 of 40 residents (R27, R30, R43, R13, R44 and R100). In addition, the facility also failed to perform timely and thorough investigations and immediately suspend RN-A and LPN-A pending the investigations. Findings include: Review of the grievances submitted from 2025 and 2026 grievances identified the following grievances: On 8/19/25, a grievance was filed regarding R100 by the former director of nursing (DON)-A. R100 reported LPN-A was rude to R100 on or about 8/5/25. R100 was “very agitated” when he was discussing his concerns to the reporter and could not describe anything specific that LPN-A said, however felt it was much more her “tone and how she said things” to him. R100 reported LPN-A was like “Sergeant Slaughter” (a professional wrestler who dressed as a military drill sergeant and known to be very harsh in behavior) and was “very stern...do as I say” person. “She just wasn’t talking nice to me”. An interview occurred with an unknown party (U)-A. R100 had called her because he was upset. He was upset about the chair and that he could not get a sleeping pill. R100 reported “this place is terrible”. U-A could not calm R100 down because he was so upset. U-A also called to speak with LPN-A. LPN-A explained R100 shouldn’t be getting up on his own and that staff would assist him. LPN-A also reported to U-A that the facility couldn’t start a sleeping pill without doing a sleep study. U-A reported she became upset with LPN-A when LPN-A had asked her if R100 had ever been married. U-A stated “no”. LPN-A said “well he must not be able to handle women well... well, you know how these old farmers are”. There was no more information provided from the interview. LPN-A was then interviewed and remarked she had asked U-A if R100 had ever been married and stated she had commented “well, maybe he just doesn’t take			F0610			

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F0610 SS = E	Continued from page 16 direction well from women”. The reported explained comments like that “came across” as unprofessional and should be avoided in the future. LPN-A admitted it wasn’t the best “word choice” but had not intended to be disrespectful or rude. LPN-A was told to “reflect on this situation and choose her words more carefully in the future”. The resolution was education had been given to LPN-A ensuring professional conversation was maintained when communicating with residents. The DON signed off on the report on 8/19/25, however, the administrator had not signed off the report until 3/5/26. No other residents and/or representatives were interviewed, nor were any other staff members interviewed. There was also no follow up noted to determine if R100 was asked if they felt safe or if there had been any effects on R100’s psychosocial or physical status with lack of a potential sleep aide that may have been able to be offered, or if R100 had any psychosocial outcome such as increased behaviors, or further instances from LPN-A with other comments etc. No other staff or residents were identified to have been interviewed to determine if similar incidents had occurred with other residents. On 11/10/25, registered nurse (RN)-B made a grievance report on behalf of R30 to DON-A, (2 days later) that on 11/8/26. R30 had reported that she heard RN-A yelling loudly at R44. RN-A then entered R30’s room and told R30 “I don’t care if he is your friend... I don’t like him; he’s not a good patient”. The facility interviewed RN-B and she reported the order of events were that R30 had told her RN-A was yelling “so loud that the building could hear”. R30 did not know specifically what RN-A had said to R44. R30 had also reported that RN-A entered her room and stated “I don’t care if he’s your friend. I don’t like him he’s not a good patient”. R30 also told several people she hoped RN-A did not treat them like that. DON-A directed RN-B to speak to R44 to see if he felt safe and ask how staff treated him. RN-B followed up with DON that R44 responded he felt safe and stated, “I don’t like being here but they’re all treating me good”. An interview with RN-A identified she denied yelling at R44. She reported she was just reminding him that he needed to ask for help. R44 was saying he was being “imprisoned” and kept getting up on his own. He also threatened to pull the fire alarm. RN-A reported R44 was basically a 1:1 due to behaviors and continual attempts to transfer. R30 was interviewed and stated she had no concerns about how RN-A treated her. DON-A had a conversation with RN-A to which RN-A denied yelling at R44 and only tried to redirect him. There was no mention the facility asked RN-A if she had spoken to R30 as			F0610			

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F0610 SS = E	Continued from page 17 noted above in the grievance as no other areas of the concern were documented. There was also no mention the facility identified the yelling would be considered an allegation of verbal abuse and should have been reported to the State agency (SA) and administrator immediately on 11/8/26, vs 2 days later on 11/10/26, and re-educated staff to what verbal abuse was, or ensured staff were timely reporting to the administrator and SA. There was also no mention the facility had interviewed other residents and/or their representatives other than R30 and R44, if they interviewed other staff, or had placed RN-A on suspension pending an investigation. The administrator signed off on the report on 11/10/25. On 11/17/25, R27 reported a concern to the administrator about RN-A was treating her. R27 reported RN-A had told her she was “going in a time-out”. R27 asked why and RN-A told her, “because you don’t know what you are doing”. R27 stated this made her feel “inadequate”. It was also noted the incident occurred on 11/15/25 or 11/16/25. The investigation identified an interview was conducted with nursing assistant (NA)-A who stated “I just want to start with and say that the day I worked with RN-A and NA-C on north, was one of the best days I worked on north. Things went smoothly”. When asked about general concerns regarding RN-A, NA-A stated, “she is assertive and bossy” and gave a random example of a resident (R43) who would go into their room in a wheelchair and staff may say to RN-A “oh they just went to their room”, and she “will drag them back out”. NA-A reported RN-A made R43 very upset that day (unknown date), and he was “snappy” because of how RN-A treated him and “he is never that way”. R43 normally would go into his room, and staff just paid attention to him if he tried to get up to go to the bathroom. NA-A further reported RN-A was also noted to be standing in front of his room blocking him from entering and said, “You can’t go in... staff will help you”. NA-A felt RN-A’s approach was the issue as she is “assertive and bossy” with the residents. RN-A was interviewed and a summary of the complaints was read to her. In the summary, it was noted R27 voiced to her family member about RN-A not allowing her into her room. RN-A denied that she yelled at residents. RN-A admitted she did block R43 from going into his room as she “did not want him to fall self-transferring”. When asked why she did not go with R43 to assist him with a transfer verse blocking him, she reported she was “worn out”. RN-A reported she does not “intend to yell” at residents. She acknowledged she may raise her voice, but that was so they could hear her. The DON			F0610			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245455		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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F0610 SS = E	Continued from page 18 directed RN-A to reflect on her tone, volume of voice, body language, and word choice. She needed to “soften her tone and approach”. RN-A was tearful reporting that she had been trying hard to change her approach since the last conversation. Attached to the grievance was an email that had been sent to the administrator and DON on 11/16/21 at 11:03 a.m., (the sender of the email had been redacted). The email identified there were a few complaints/concerns regarding RN-A over the weekend (unknown if that was 11/15/25 or 11/16/25 weekend or prior). The email identified on Thursday (presumably 11/13/25) RN-A had “very much upset” R13 and had her “all worked up” as RN-A “yelled” at her for hollering out. Nurse aide (NA)-B had to console R13 as she kept saying “she yelled at me”. The unknown author of the email identified being told by multiple people that RN-A “hollered” at certain residents as they attempted to self-transfer. RN-A would get mad at the residents and scold them for self-transferring. The unknown author identified that NA-A reported RN-A would not let certain residents go back into their room as RN-A stated, “they can’t be in their rooms in a wheelchair” and stating “you can’t be in here” standing in front of R43’s door scolding him and not letting R27 go back to her room and “jumping down [R44’s] throat” when he self-transferred. The unknown author identified R27 was the most upset about this and refused to go to supper because she would “get yelled at”. R44 stated he was “sick of that big lady hollering at him” and apparently R43 was very upset on the day [shift] also. The unknown author reported they had heard on multiple cases of RN-A hollering or scolding residents and “that was not ok, and the residents deserved better than this”. 3 residents were interviewed along with R27. R27 had complaints of treatment and reported RN-A kept saying to her “you’re just going to timeout” and “kept putting her in a timeout”. When R27 asked why, RN-A told R27, “you don’t know what you are doing”. The questions about staff talking respectfully to others and if she felt safe here were blank. The question about who to report to R27 had reported she would talk with her daughter. The other 3 residents felt like they were treated respectfully and had no concerns. None of the interviews were dated when they occurred or identified who asked the questions. The resolution section and follow-up comments on the grievance report were left blank. There was no indication the administrator or DON acted per the facility policy on the alleged allegations of verbal abuse and involuntary, that a formal investigation occurred, nor mention that RN-A had been suspended while the facility investigated the recurring concerns, staff			F0610			

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F0610 SS = E	Continued from page 19 re-educated about reporting or if the facility identified potential burnout by RN-A's comments. The administrator signed off the report on 3/5/26. Interview on 7/29/26 at 3:26 p.m. with regional clinical service director identified the grievance forms were missing information including a thorough investigation of each grievance with follow up to the concerned party. She agreed that the facility should have acted upon that email and the grievances (allegations of verbal abuse and involuntary seclusion) should have resulted in the suspension of RN-A and the administration should have immediately started an investigation. She revealed in all the grievances reviewed from November and December 2025, there seemed to be a pattern of only interviewing the parties identified in the concern and agreed that further interviews should have been completed to ensure a thorough investigation had occurred. She further agreed that the resolution and follow-up with the party concerned was lacking in most of the reviewed grievances and should have been completed per facility policy to ensure a satisfactory resolution. Her expectation was that the facility would brainstorm to ensure all grievances were handled and resolved appropriately. She made no mention the grievances were allegations of verbal abuse and involuntary seclusion and should have been reported to the SA immediately. Interview on 7/30/26 at 8:07 a.m., with the administrator identified he felt the facility did start an investigation. The DON-A was to complete the investigation and that was why he had not participated in it. He reached out to DON-A who reported the concern. DON-A did educate RN-A but did not document that education. The facility completed interviews with residents last night (7/29/26) (nine after the incidents) and suspended RN-A while a new investigation was being conducted. He stated there was no verbal abuse identified and the situation "had been handled" as R27 had no concerns and there had been "no lasting effect, and no signs of psychosocial distress". The administrator declined to answer if RN-A should have been suspended when the incidents occurred for R30 and R44 in order to potentially prevent further incidents with R27 and other residents. Review of the 4/7/25, Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy and Rehab policy identified the policy was created to			F0610			

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F0610 SS = E	Continued from page 20 ensure employees were knowledgeable regarding the reporting and investigative process of abuse and neglect allegations, and ensure an effective system was in place that prevented mistreatment, neglect and abuse. It was also designed to ensure a complete review by the investigative team was completed to identify allegations of abuse and neglect were promptly reported and investigated. Allegations involving mistreatment, neglect, or abuse were to be reported immediately to the administrator in order to intervene and protect residents. With an allegation of employee to resident abuse, the employee was to be removed from providing direct care to all residents. And be placed on suspension pending the results of the investigation. Allegations were to be reported immediately but no later than 2 hours after the allegation was made. Allegations that did not involve abuse and had no serious bodily injury were to be reported no later than 24 hours after the allegation was made. The investigation team (social worker (SW), DON and administrator) were to review all events no later than the next working day following the event. The facility was to ensure someone was assigned to complete the investigation and the SW or designee was to notify the SA. The investigation was to include interviewing employees, residents and/or witnesses to the event, but made no mention of interviewing others not directly involved but who may have knowledge about other pertinent facts or data of incidents. The SW or designee was to report results of all investigations to the SA within 5 working days of the event.			F0610			
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in			F0609			

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F0609 SS = D	Continued from page 21 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to report allegations of verbal abuse and threats of involuntary seclusion, related to 2 of 2 staff (registered nurse (RN)-A) and licensed practical nurse (LPN)-A) to the State Agency. Findings include: Review of the grievances submitted from 2025 and 2026 grievances identified the following grievances: On 8/19/25, a grievance was filed regarding R100 by the former director of nursing (DON)-A. R100 reported LPN-A was rude to R100 on or about 8/5/25. R100 was “very agitated” when he was discussing his concerns to the reporter and could not describe anything specific that LPN-A said, however felt it was much more her “tone and how she said things” to him. R100 reported LPN-A was like “Sergeant Slaughter” (a professional wrestler who dressed as a military drill sergeant and known to be very harsh in behavior) and was “very stern...do as I say” person. “She just wasn’t talking nice to me”. An interview occurred with an unknown party (U)-A. R100 had called her because he was upset. He was upset about the chair and that he could not get a sleeping pill. R100 reported “this place is terrible”. U-A could not calm R100 down because he was so upset. U-A also called to speak with LPN-A. LPN-A explained R100 shouldn’t be getting up on his own and that staff would assist him. LPN-A also reported to U-A that the facility couldn’t start a sleeping pill without doing a sleep study. U-A reported she became upset with LPN-A when LPN-A had asked her if R100 had ever been married. U-A stated “no”. LPN-A said “well he must not be able to handle women well... well, you know how these old farmers are”. There was no more information provided from the interview. LPN-A was then interviewed and remarked she had asked U-A if R100 had ever been married and stated she had			F0609			

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F0609 SS = D	Continued from page 22 commented “well, maybe he just doesn’t take direction well from women”. The reported explained comments like that “came across” as unprofessional and should be avoided in the future. LPN-A admitted it wasn’t the best “word choice” but had not intended to be disrespectful or rude. LPN-A was told to “reflect on this situation and choose her words more carefully in the future”. The resolution was education had been given to LPN-A ensuring professional conversation was maintained when communicating with residents. The DON signed off on the report on 8/19/25, however, the administrator had not signed off the report until 3/5/26. No report was made to the SA. On 11/10/25, registered nurse (RN)-B made a grievance report on behalf of R30 to DON-A, (2 days later) that on 11/8/26. R30 had reported that she heard RN-A yelling loudly at R44. RN-A then entered R30’s room and told R30 “I don’t care if he is your friend... I don’t like him; he’s not a good patient”. The facility interviewed RN-B and she reported the order of events were that R30 had told her RN-A was yelling “so loud that the building could hear”. R30 did not know specifically what RN-A had said to R44. R30 had also reported that RN-A entered her room and stated “I don’t care if he’s your friend. I don’t like him he’s not a good patient”. R30 also told several people she hoped RN-A did not treat them like that. DON-A directed RN-B to speak to R44 to see if he felt safe and ask how staff treated him. RN-B followed up with DON that R44 responded he felt safe and stated, “I don’t like being here but they’re all treating me good”. An interview with RN-A identified she denied yelling at R44. She reported she was just reminding him that he needed to ask for help. R44 was saying he was being “imprisoned” and kept getting up on his own. He also threatened to pull the fire alarm. RN-A reported R44 was basically a 1:1 due to behaviors and continual attempts to transfer. R30 was interviewed and stated she had no concerns about how RN-A treated her. DON-A had a conversation with RN-A to which RN-A denied yelling at R44 and only tried to redirect him. There was no mention the identified the yelling would be considered an allegation of verbal abuse and should have been reported to the State agency (SA) and administrator immediately on 11/8/26. The administrator signed off on the report on 11/10/25. On 11/17/25, R27 reported a concern to the administrator about RN-A was treating her. R27 reported RN-A had told her she was “going in a time-out”. R27 asked why and RN-A told her “because you don’t know what you are doing”. R27			F0609			

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F0609 SS = D	Continued from page 23 stated this made her feel “inadequate”. It was also noted the incident occurred on 11/15/25 or 11/16/25. The investigation identified an interview was conducted with nursing assistant (NA)-A who stated “I just want to start with and say that the day I worked with RN-A and NA-C on north, was one of the best days I worked on north. Things went smoothly”. When asked about general concerns regarding RN-A, NA-A stated, “she is assertive and bossy” and gave a random example of a resident (R43) who would go into their room in a wheelchair and staff may say to RN-A “oh they just went to their room”, and she “will drag them back out”. NA-A reported RN-A made R43 very upset that day (unknown date), and he was “snappy” because of how RN-A treated him and “he is never that way”. R43 normally would go into his room, and staff just paid attention to him if he tried to get up to go to the bathroom. NA-A further reported RN-A was also noted to be standing in front of his room blocking him from entering and said, “You can’t go in... staff will help you”. NA-A felt RN-A’s approach was the issue as she is “assertive and bossy” with the residents. RN-A was interviewed and a summary of the complaints was read to her. In the summary, it was noted R27 voiced to her family member about RN-A not allowing her into her room. RN-A denied that she yelled at residents. RN-A admitted she did block R43 from going into his room as she “did not want him to fall self-transferring”. When asked why she did not go with R43 to assist him with a transfer verse blocking him, she reported she was “worn out”. RN-A reported she does not “intend to yell” at residents. She acknowledged she may raise her voice, but that was so they could hear her. The DON directed RN-A to reflect on her tone, volume of voice, body language, and word choice. She needed to “soften her tone and approach”. RN-A was tearful reporting that she had been trying hard to change her approach since the last conversation. Attached to the grievance was an email that had been sent to the administrator and DON on 11/16/21 at 11:03 a.m., (the sender of the email had been redacted). The email identified there were a few complaints/concerns regarding RN-A over the weekend (unknown if that was 11/15/25 or 11/16/25 weekend or prior). The email identified on Thursday (presumably 11/13/25) RN-A had “very much upset” R13 and had her “all worked up” as RN-A “yelled” at her for hollering out. Nurse aide (NA)-B had to console R13 as she kept saying “she yelled at me”. The unknown author of the email identified being told by multiple people that RN-A “hollered” at certain residents as they attempted to self-transfer. RN-A would get mad at the residents and scold them for self-transferring. The unknown author			F0609			

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F0609 SS = D	Continued from page 24 identified that NA-A reported RN-A would not let certain residents go back into their room as RN-A stated, “they can’t be in their rooms in a wheelchair” and stating “you can’t be in here” standing in front of R43’s door scolding him and not letting R27 go back to her room and “jumping down [R44’s] throat” when he self-transferred. The unknown author identified R27 was the most upset about this and refused to go to supper because she would “get yelled at”. R44 stated he was “sick of that big lady hollering at him” and apparently R43 was very upset on the day [shift] also. The unknown author reported they had heard on multiple cases of RN-A hollering or scolding residents and “that was not ok, and the residents deserved better than this”. 3 residents were interviewed along with R27. R27 had complaints of treatment and reported RN-A kept saying to her “you’re just going to timeout” and “kept putting her in a timeout”. When R27 asked why, RN-A told R27, “you don’t know what you are doing”. The questions about staff talking respectfully to others and if she felt safe here were blank. The question about who to report to R27 had reported she would talk with her daughter. The other 3 residents felt like they were treated respectfully and had no concerns. None of the interviews were dated when they occurred or identified who asked the questions. The resolution section and follow-up comments on the grievance report were left blank. The administrator signed off the report on 3/5/26. There was no indication the administrator or DON acted per the facility policy on the alleged allegations of verbal abuse and involuntary and reported the allegations to the SA. Interview on 7/29/26 at 3:26 p.m. with regional clinical service director identified the grievance forms were missing information including a thorough investigation of each grievance with follow up to the concerned party. She agreed that the facility should have acted upon that email and the grievances (allegations of verbal abuse and involuntary seclusion) should have resulted in the suspension of RN-A and the administration should have immediately started an investigation. She revealed in all the grievances reviewed from November and December 2025, there seemed to be a pattern of only interviewing the parties identified in the concern and agreed that further interviews should have been completed to ensure a thorough investigation had occurred. She further agreed that the resolution and follow-up with the party concerned was lacking in most of the reviewed grievances and should have been completed per facility policy to ensure a satisfactory resolution. Her expectation was that the			F0609			

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F0609 SS = D	Continued from page 25 facility would brainstorm to ensure all grievances were handled and resolved appropriately. She made no mention the grievances were allegations of verbal abuse and involuntary seclusion and should have been reported to the SA immediately. Interview on 7/30/26 at 8:07 a.m., with the administrator identified he felt the facility did start an investigation. The DON-A was to complete the investigation and that was why he had not participated in it. He reached out to DON-A who reported the concern. DON-A did educate RN-A but did not document that education. The facility completed interviews with residents last night (7/29/26) (nine after the incidents) and suspended RN-A while a new investigation was being conducted. He stated there was no verbal abuse identified and the situation “had been handled” as R27 had no concerns and there had been “no lasting effect, and no signs of psychosocial distress”. The administrator declined to answer if RN-A should have been suspended when the incidents occurred for R30 and R44 in order to potentially prevent further incidents with R27 and other residents. Review of the 4/7/25, Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy and Rehab policy identified the policy was created to ensure employees were knowledgeable regarding the reporting and investigative process of abuse and neglect allegations, and ensure an effective system was in place that prevented mistreatment, neglect and abuse. It was also designed to ensure a complete review by the investigative team was completed to identify allegations of abuse and neglect were promptly reported and investigated. Allegations involving mistreatment, neglect, or abuse were to be reported immediately to the administrator in order to intervene and protect residents. With an allegation of employee to resident abuse, the employee was to be removed from providing direct care to all residents. And be placed on suspension pending the results of the investigation. Allegations were to be reported immediately but no later than 2 hours after the allegation was made. Allegations that did not involve abuse and had no serious bodily injury were to be reported no later than 24 hours after the allegation was made. The investigation team (social worker (SW), DON and administrator) were to review all events no later than the next working day following the event. The facility was to ensure someone was assigned to complete the investigation and the SW or designee was to notify the SA. The			F0609			

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F0609 SS = D	Continued from page 26 investigation was to include interviewing employees, residents and/or witnesses to the event, but made no mention of interviewing others not directly involved but who may have knowledge about other pertinent facts or data of incidents. The SW or designee was to report results of all investigations to the SA within 5 working days of the event.			F0609			
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the designated State Mental Health Authority (SMHA) for 1 of 1 sampled resident (R8) who had a mental illness diagnosis not identified on the Pre Admission Screen (PAS). Findings include: R8’s 5/23/26, accepted quarterly Minimum Data Set (MDS) assessment identified her cognition was intact and she did not display any behaviors during the assessment period. R8 had a diagnosis of bipolar disorder (a mental health condition characterized by significant mood swings). R8’s Pre Admission Screen (PAS) level I completed on 10/09/2020, indicated R8 did not have a diagnosis of bipolar disorder or other mental illness, and a level II assessment was not required.			F0644			

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F0644 SS = D	Continued from page 27 R8's 7/29/26, diagnosis report identified R8 had diagnosis of bipolar disorder added on 4/29/21. R8's medical record lacked evidence R8 was referred to the SMHA after the identification of the bipolar disorder diagnosis. Interview on 7/29/26 at 1:38 p.m., with social service designee (SSD) identified she had not been reviewing the PAS to ensure a level II screening was completed if needed. She confirmed she had not notified the county for a level II however, R8 was being seen by psychiatry. She reported she had never done a level II referral to the local authority and had always just gone by what the PAS indicated. Interview on 7/30/26 at 11:30 a.m., with regional clinical service director identified the facility should be reviewing the PAS for accuracy and should follow up with the mental health authority if a mental illness was identified as a diagnosis and not identified on the PAS for a level II screening. Review of the 12/29/25, Pre-Admission Screening and Resident Review (PASARR) policy identified residents would be screened for mental illness prior to admission. The PASARR was a level I screening and completed prior to admission to identify mental illness or related condition who then would need a level II screening and determination prior to admission. These screenings ensure that a resident who has a mental health disorder or related condition will be offered the most appropriate setting and services to meet their needs. A positive level I screening requires a level II screening by a state designated authority. The policy identified that the level I screening would be reviewed by the admissions coordinator, social services, or designated individual to determine whether a level II screening was required.			F0644			
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them			F0755			

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F0755 SS = D	Continued from page 28 under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident was discharged home with non-controlled medications. Findings include: R39's accepted 5/8/26, accepted Minimum Data Set (MDS) assessment identified he was re-admitted to the facility the beginning of April 2026 for rehabilitation following a surgical procedure, and discharged 4/29/26. R39 had diagnoses of a wedge compression fracture of (spinal fracture where the front of a vertebra collapses while the back stays intact), pulmonary fibrosis (lung disease that occurs when lung tissue becomes damaged and scarred making it harder for the lungs to work properly) heart disease, high blood pressure, Barrett's esophagus (damage to windpipe caused by acid reflux) ventricular tachycardia and supraventricular tachycardia (potentially life threatening arrhythmias that can lead to cardiac arrest) , pneumonia, and			F0755			

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F0755 SS = D	Continued from page 29 pulmonary embolism (blood clot in lungs (PE)). R39's Medication Administration Record (MAR), in effect at the time of discharge on 4/29/26, identified R39 was receiving: Diltiazem (anti-arrhythmic medication to stabilize heart rate) extended release, 120 milligrams (mg) daily. Lidocaine patch 4% (used for pain control), to be applied topically to the lower back related to his wedge fracture, 1 x per day. Pantoprazole (prescription antacid) 20 mg daily for Barrett's esophagus treatment. Apixaban (blood thinner) 5 mg twice daily (BID) for diagnosis of PE. Mupirocin 2 % (antibiotic ointment) to be applied under his nose every 12 hours. Trolamine Salicylate 10% (pain cream). R39's discharge notes identified R39 was only sent home with his mupirocin ointment and the trolamine ointment. All other current prescriptions were sent to the local pharmacy for new prescriptions. Email correspondence on 7/30/26 at 8:16 a.m., with the MDS nurse (MDS-A) identified they had not sent R39's other medications home with him upon his discharge, just what was indicated in the discharge notes. There was no mention if this was the usual facility practice when asked. Follow-up email from MDS-A on 7/13/26 at 10:39 a.m., identified she spoke with the discharge nurse who relayed staff may send any bottled medications that are ordered, and they are discharging home on. That may include OTC medication, lotions, creams and we would document what was sent with the resident in the note if that was the scenario. Review of the 8/29/26, Medication: Disposition (Disposal) policy identified there was no mention of direction for staff, when a non-controlled medication was in effect at the time of discharge, that the remainder was to be sent with the resident upon discharge or at minimum. The policy only directed staff for the disposal of any medication was to be carried out under local, state and federal guidelines			F0755			

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F0755 SS = D	Continued from page 30 or in consultation of the pharmacist in the appropriate disposal procedure. Documentation was to include the resident's name, medication name, prescription number (as applicable), quantity, date of disposition and the staff member involved, consultant or other applicable individuals.			F0755			
F0847 SS = D	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.			F0847			

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F0847 SS = D	Continued from page 31 §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the binding arbitration agreement was fully explained in a manner they or their representatives understood, including their right to not sign the agreement, for 3 of 4 residents (R31, R6, R40) reviewed for arbitration. Findings include: Review of the undated facility resident listing report identified R31, R6, and R40's Arbitration Agreement Response was yes. R31's comprehensive Minimum Data Set (MDS) assessment accepted on 7/31/26, identified she admitted to the facility on 7/15/26, and her cognition was moderately impaired. Review of R31's medical record identified that her resident representative/family member (FM)-A signed a Resolution of Legal Disputes/Arbitration Agreement on 7/15/26. Interview on 7/28/26 at 3:00 p.m., with FM-A identified she did not know what arbitration was. She did not recall the facility explaining it to her and did not recall signing an agreement. FM-A picked up a folder and said this is everything they gave me on admission day, the folder did not contain a copy of the arbitration agreement. FM-A identified she would like a copy of the agreement so she could review it before the 30 days were up. R6's comprehensive MDS accepted on 6/26/26, identified she was admitted on 6/11/26 and her cognition was intact. Review of R6's medical record identified her representative/family member had signed an			F0847			

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F0847 SS = D	Continued from page 32 arbitration agreement on the day of admission 6/11/26. Interview on 7/29/26 at 4:30 p.m., with FM-B identified she was not sure if they explained arbitration to her. She was not aware that she agreed not to use courts if they had a dispute. She identified the day of the admission as a hectic day and she had to sign a lot of papers. She was not sure that she would have agreed to the arbitration if she would have understood what it was. She further identified that she was very overwhelmed that day and she made that known to the facility. R40's Entry MDS identified she was admitted on 7/21/26. Review of R40's medical record identified she had signed an arbitration agreement on the day of admission 7/21/26. Interview on 7/29/26 at 11:01 a.m., with R40 identified she was not aware of what arbitration was, she did not recall being given an explanation of what arbitration was and did not recall signing an Arbitration Agreement. She reviewed her folder that had been provided by the facility with her admission paperwork and said she did not receive a copy of the agreement. Interview on 7/28/26 at 2:23 p.m., with the social service designee (SSD) identified, sometimes she went through the paperwork quickly because the resident and/or representative didn't want to hear all the details of the admission paperwork. She asked them if there was a legal dispute would they be willing to work with an unrelated arbitrator to resolve a legal dispute, if they answered no, then she said if there was a legal dispute they could obtain council and the facility would obtain council and they would go through the court system. She identified that she did not go into detail and did not provide a copy of anything unless they asked for it. Interview on 7/29/26 at 11:03 a.m., with the administrator identified he had received training upon hire that they were to tell residents that arbitration meant working with a third party that did not represent the facility or the resident and avoided going to court. He was not sure if they were			F0847			

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F0847 SS = D	Continued from page 33 required to give the resident and/or the resident representative a copy of the agreement. The administrator said it could not be proven that the resident and/or representative did not receive a copy because they could have taken it home and that it was a moot point. They did not have the residents or representatives explain their understanding of the agreement prior to having them sign it. A policy was requested but nothing was provided by the end of the survey period.			F0847			
F0949 SS = D				F0949			
Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure 1 of 8 sampled staff (nurse aide (NA)-E) reviewed for annual required Alzheimer's Disease and Related Disorders training had been completed. Findings include: Review on 8/30/26 of the requested annual Alzheimer's and dementia training for 8 sampled staff identified nursing assistant (NA)-E failed to complete the required annual training. Interview on 8/30/26 at 1:30 p.m., with the administrator identified NA-E had failed to complete the annual training. They typically assign the training in their online training program; however, he had not realized NA-A had failed to complete his required training. A policy was requested but nothing was provided by the end of the survey period.							

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/27/26 through 7/31/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed:			20000			

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 H54553457C (2656440) and H54553458C (2655855). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.			20000			
20302	Alzheimer's disease or related disorder train CFR(s): MN State Statute 144.6503 ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503			20302			

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20302	Continued from page 2 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure 1 of 8 staff sampled for annual required Alzheimer's Disease and Related Disorders training had been completed. Findings include: Review on 8/30/26 of the requested annual Alzheimer's and dementia training for 8 sampled staff identified nursing assistant (NA)-E failed to complete the required annual training. Interview on 8/30/26 at 1:30 p.m., with the administrator identified NA-E had failed to complete the annual training. They typically assign the training in their online training program; however, he had not realized NA-A had failed to complete his required training.			20302			

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20302	Continued from page 3 A policy was requested but nothing was provided by the end of the survey period. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee should review and revise policies and procedures related to ensuring the Alzheimer's training is provided in written or electronic form, to residents and families or other persons who request it, describing the training program and the related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. The administrator, director of nursing, or designee should develop a system to educate staff and develop a monitoring system to ensure compliance as directed by the written plan of care. The facility should report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations and ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20302				
21000	Dietary Staff Requirements-Hygiene. CFR(s): MN Rule 4658.0610 Subp. 4 Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure infection control measures were followed during observation of 1 of 1 meal services. This had the potential to effect all 36 residents in the facility. Findings include: Observation on 7/29/26 at 11:29 a.m. as cook-A completed preparation of the noon meal consisting of chicken with mushroom gravy, noodles, and		21000				

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21000	Continued from page 4 broccoli. Cook-A was placing the food items onto the steam table when she turned and went to the cabinet, opened the door, removed a saltshaker, and shook salt into her bare hand. After filling the palm of her hand with salt she returned to the stove, where she dumped the salt from her hand into the cooking noodles. When questioned as to her action, she replied she had measured the salt to add to the noodles. She then asked if this was a problem as that was how she always did it. Cook-A then set the pot into the sink and prepared a fresh pot of noodles which were placed onto the steam table. As she was pouring the noodles into the steamtable pan several noodles landed on the counter Infront of the pan. Cook-A used her bare hand and tossed the noodles from the counter back into the pan of noodles in the steamtable. Observation on 7/29/26 at 11:42 a.m. as cook-A washed her hands, returned to the counter across from the steamtable, where she picked up a tray containing 2 paper meal slips, picked up the slips and identified the resident meals, turned back to the steamtable, picked up 2 plates, and began placing food items onto the plates. She used a large, slotted spoon to scoop noodles onto the plates, then placed the slotted spoon on the side of the steamtable, went around the steamtable to a drawer which she opened with her bare hand, removed a green handle scoop spoon and returned to plating the meal. As she was scooping noodles onto the plate, several noodles were hanging off the side of the plate, and she used her bare hand to scoop them back onto the plate. Cook-A placed the filled plates onto the tray and pushed them into the window for staff to serve to residents in the dining room. Cook-A continued the same process of serving several plates and again used her bare hand to scoop noodles hanging off the side of the plate back onto the plate being served. Observation on 7/29/26 at 11:52 a.m. as cook-A left the steamtable, walked into the dining room where she went to trays set-up on a cart, and identified as room trays. She returned to the steamtable with no hand hygiene and continued to plate meals, covered with a lid, and after stacking 4 covered plates, she took them into the dining room and placed them onto the trays designated as room trays. Cook-A then returned to the kitchen, took a cloth from the bucket of sanitizer solution in the sink and began wiping down the counter and cart that had contained the pudding served for dessert.			21000			

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21000	Continued from page 5 Interview on 7/29/26 at 12:05 p.m. with cook-A reported she had always measured seasonings using her hand and was not aware there was a problem doing it that way. When asked about serving of the noodles and handling them with her bare hands, reported she did not realize she had done that and reported she should have, tossed the noodles that landed on the counter Infront of the steam pan, and used the scoop to position noodles on to plates instead of her hand. Interview on 7/29/26 at 12:15 p.m. with the certified dietary manager (CDM) identified her expectation for infection control practices to be followed in the kitchen. She reported she was not aware cook-A used her bare hand to measure spices, and she should have used measuring spoons, not her hand. Regarding touching food with bare hands was not acceptable practice, and she expected staff to use utensils and appropriate hand hygiene practices. She identified anytime staff left the steam table area; they needed to use hand hygiene before returning to serving food. Interview on 7/29/26 at 1:30 p.m. with the infection preventionist (IP) identified her expectation for all departments to follow appropriate infection control practices by utilizing hand hygiene practices. Review of the 7/14/26, Sandford Policy Food Handling-Food and Nutrition identified prevention of food related illness to a highly susceptible population in the facility. This was identified as the need for handling of food in a manner to decrease the risk of contamination. The procedure identified food items were not to be touched using bare hands. Utensils including tissue, spatulas, tongs and single-use gloves were to be utilized when handling food items. Hand hygiene was identified as washing with soap and water and gloves were to be utilized when indicated due to needing to tough a food item. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate hand hygiene measures are followed during preparation and serving of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate utensils are utilized during food preparation. The facility could update or create			21000			

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21000	Continued from page 6 policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21000				
21625	Disposition of Medications; On Discharge CFR(s): MN Rule 4658.1350 Subp. 1 Subpart 1. Drugs given to discharged residents. Current medications, except controlled substances listed in Minnesota Statutes, section 152.02, subdivision 3, belonging to a resident must be given to the resident, or the resident's legal guardian or designated representative, when discharged or transferred and must be recorded on the clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident was discharged home with non-controlled medications. Findings include: R39's accepted 5/8/26, accepted Minimum Data Set (MDS) assessment identified he was re-admitted to the facility the beginning of April 2026 for rehabilitation following a surgical procedure, and discharged 4/29/26. R39 had diagnoses of a wedge compression fracture of (spinal fracture where the front of a vertebra collapses while the back stays intact), pulmonary fibrosis (lung disease that occurs when lung tissue becomes damaged and scarred making it harder for the lungs to work properly) heart disease, high blood pressure, Barrett's esophagus (damage to windpipe caused by acid reflux) ventricular tachycardia and supraventricular tachycardia (potentially life threatening arrhythmias that can lead to cardiac arrest) , pneumonia, and pulmonary embolism (blood clot in lungs (PE)). R39's Medication Administration Record (MAR), in effect at the time of discharge on 4/29/26, identified		21625				

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21625	Continued from page 7 R39 was receiving: Diltiazem (anti-arrhythmic medication to stabilize heart rate) extended release, 120 milligrams (mg) daily. Lidocaine patch 4% (used for pain control), to be applied topically to the lower back related to his wedge fracture, 1 x per day. Pantoprazole (prescription antacid) 20 mg daily for Barrett's esophagus treatment. Apixaban (blood thinner) 5 mg twice daily (BID) for diagnosis of PE. Mupirocin 2 % (antibiotic ointment) to be applied under his nose every 12 hours. Trolamine Salicylate 10% (pain cream). R39's discharge notes identified R39 was only sent home with his mupirocin ointment and the trolamine ointment. All other current prescriptions were sent to the local pharmacy for new prescriptions. Email correspondence on 7/30/26 at 8:16 a.m., with the MDS nurse (MDS-A) identified they had not sent R39's other medications home with him upon his discharge, just what was indicated in the discharge notes. There was no mention if this was the usual facility practice when asked. Follow-up email from MDS-A on 7/13/26 at 10:39 a.m., identified she spoke with the discharge nurse who relayed staff may send any bottled medications that are ordered, and they are discharging home on. That may include OTC medication, lotions, creams and we would document what was sent with the resident in the note if that was the scenario. Review of the 8/29/26, Medication: Disposition (Disposal) policy identified there was no mention of direction for staff, when a non-controlled medication was in effect at the time of discharge, that the remainder was to be sent with the resident upon discharge or at minimum. The policy only directed staff for the disposal of any medication was to be carried out under local, state and federal guidelines or in consultation of the pharmacist in the appropriate disposal procedure. Documentation was to include the resident's name, medication name, prescription number (as applicable), quantity, date of disposition and the staff member involved,			21625			

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21625	Continued from page 8 consultant or other applicable individuals. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) in collaboration with the pharmacist and/or designee should review policies and procedures for medication dispensation upon discharge to include processes on how medication will be sent with the resident (except for controlled substances) upon discharge. Staff should be educated on the need to ensure residents' current medications are given to the resident or the resident's legal guardian or designated representative when discharged or transferred and recorded in the clinical record. The DON, pharmacist and/or designee should review and audit all current residents who have anticipation of discharge to ensure dispensation of current medications when discharged or transferred occurs. The DON, Pharmacist and/or designee should take the results of those audits to the Quality Assurance Performance Improvement Committee (QAPI) to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21625			
21980	Reporting - Maltreatment of Vulnerable Adults CFR(s): MN St. Statute 626.557 Subd. 3 Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the			21980			

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21980	Continued from page 9 provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to report allegations of verbal abuse and threats of involuntary seclusion, related to 2 of 2 staff (registered nurse (RN)-A) and licensed practical nurse (LPN)-A) to the State Agency. Findings include: Review of the grievances submitted from 2025 and 2026 grievances identified the following grievances: On 8/19/25, a grievance was filed regarding R100 by the former director of nursing (DON)-A. R100 reported LPN-A was rude to R100 on or about 8/5/25. R100 was “very agitated” when he was discussing his concerns to the reporter and could not describe anything specific that LPN-A said, however felt it was much more her “tone and how she said things” to him. R100 reported LPN-A was like “Sergeant Slaughter” (a professional wrestler who dressed as a military drill sergeant and known to be very harsh in behavior) and was “very stern...do as I say” person. “She just wasn’t talking nice to me”. An interview occurred with an unknown			21980			

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21980	Continued from page 10 party (U)-A. R100 had called her because he was upset. He was upset about the chair and that he could not get a sleeping pill. R100 reported “this place is terrible”. U-A could not calm R100 down because he was so upset. U-A also called to speak with LPN-A. LPN-A explained R100 shouldn't be getting up on his own and that staff would assist him. LPN-A also reported to U-A that the facility couldn't start a sleeping pill without doing a sleep study. U-A reported she became upset with LPN-A when LPN-A had asked her if R100 had ever been married. U-A stated “no”. LPN-A said “well he must not be able to handle women well... well, you know how these old farmers are”. There was no more information provided from the interview. LPN-A was then interviewed and remarked she had asked U-A if R100 had ever been married and stated she had commented “well, maybe he just doesn't take direction well from women”. The reported explained comments like that “came across” as unprofessional and should be avoided in the future. LPN-A admitted it wasn't the best “word choice” but had not intended to be disrespectful or rude. LPN-A was told to “reflect on this situation and choose her words more carefully in the future”. The resolution was education had been given to LPN-A ensuring professional conversation was maintained when communicating with residents. The DON signed off on the report on 8/19/25, however, the administrator had not signed off the report until 3/5/26. No report was made to the SA. On 11/10/25, registered nurse (RN)-B made a grievance report on behalf of R30 to DON-A, (2 days later) that on 11/8/26. R30 had reported that she heard RN-A yelling loudly at R44. RN-A then entered R30's room and told R30 “I don't care if he is your friend... I don't like him; he's not a good patient”. The facility interviewed RN-B and she reported the order of events were that R30 had told her RN-A was yelling “so loud that the building could hear”. R30 did not know specifically what RN-A had said to R44. R30 had also reported that RN-A entered her room and stated “I don't care if he's your friend. I don't like him he's not a good patient”. R30 also told several people she hoped RN-A did not treat them like that. DON-A directed RN-B to speak to R44 to see if he felt safe and ask how staff treated him. RN-B followed up with DON that R44 responded he felt safe and stated, “I don't like being here but they're all treating me good”. An interview with RN-A identified she denied yelling at R44. She reported she was just reminding him that he needed to ask for help. R44 was saying he was being “imprisoned” and kept getting up on his own. He also threatened to pull the fire alarm. RN-A			21980			

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21980	Continued from page 11 reported R44 was basically a 1:1 due to behaviors and continual attempts to transfer. R30 was interviewed and stated she had no concerns about how RN-A treated her. DON-A had a conversation with RN-A to which RN-A denied yelling at R44 and only tried to redirect him. There was no mention the identified the yelling would be considered an allegation of verbal abuse and should have been reported to the State agency (SA) and administrator immediately on 11/8/26. The administrator signed off on the report on 11/10/25. On 11/17/25, R27 reported a concern to the administrator about RN-A was treating her. R27 reported RN-A had told her she was “going in a time-out”. R27 asked why and RN-A told her “because you don’t know what you are doing”. R27 stated this made her feel “inadequate”. It was also noted the incident occurred on 11/15/25 or 11/16/25. The investigation identified an interview was conducted with nursing assistant (NA)-A who stated “I just want to start with and say that the day I worked with RN-A and NA-C on north, was one of the best days I worked on north. Things went smoothly”. When asked about general concerns regarding RN-A, NA-A stated, “she is assertive and bossy” and gave a random example of a resident (R43) who would go into their room in a wheelchair and staff may say to RN-A “oh they just went to their room”, and she “will drag them back out”. NA-A reported RN-A made R43 very upset that day (unknown date), and he was “snappy” because of how RN-A treated him and “he is never that way”. R43 normally would go into his room, and staff just paid attention to him if he tried to get up to go to the bathroom. NA-A further reported RN-A was also noted to be standing in front of his room blocking him from entering and said, “You can’t go in... staff will help you”. NA-A felt RN-A’s approach was the issue as she is “assertive and bossy” with the residents. RN-A was interviewed and a summary of the complaints was read to her. In the summary, it was noted R27 voiced to her family member about RN-A not allowing her into her room. RN-A denied that she yelled at residents. RN-A admitted she did block R43 from going into his room as she “did not want him to fall self-transferring”. When asked why she did not go with R43 to assist him with a transfer verse blocking him, she reported she was “worn out”. RN-A reported she does not “intend to yell” at residents. She acknowledged she may raise her voice, but that was so they could hear her. The DON directed RN-A to reflect on her tone, volume of voice, body language, and word choice. She needed to “soften her tone and approach”. RN-A was tearful reporting that she had been trying hard to change			21980			

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21980	Continued from page 12 her approach since the last conversation. Attached to the grievance was an email that had been sent to the administrator and DON on 11/16/21 at 11:03 a.m., (the sender of the email had been redacted). The email identified there were a few complaints/concerns regarding RN-A over the weekend (unknown if that was 11/15/25 or 11/16/25 weekend or prior). The email identified on Thursday (presumably 11/13/25) RN-A had “very much upset” R13 and had her “all worked up” as RN-A “yelled” at her for hollering out. Nurse aide (NA)-B had to console R13 as she kept saying “she yelled at me”. The unknown author of the email identified being told by multiple people that RN-A “hollered” at certain residents as they attempted to self-transfer. RN-A would get mad at the residents and scold them for self-transferring. The unknown author identified that NA-A reported RN-A would not let certain residents go back into their room as RN-A stated, “they can’t be in their rooms in a wheelchair” and stating “you can’t be in here” standing in front of R43’s door scolding him and not letting R27 go back to her room and “jumping down [R44’s] throat” when he self-transferred. The unknown author identified R27 was the most upset about this and refused to go to supper because she would “get yelled at”. R44 stated he was “sick of that big lady hollering at him” and apparently R43 was very upset on the day [shift] also. The unknown author reported they had heard on multiple cases of RN-A hollering or scolding residents and “that was not ok, and the residents deserved better than this”. 3 residents were interviewed along with R27. R27 had complaints of treatment and reported RN-A kept saying to her “you’re just going to timeout” and “kept putting her in a timeout”. When R27 asked why, RN-A told R27, “you don’t know what you are doing”. The questions about staff talking respectfully to others and if she felt safe here were blank. The question about who to report to R27 had reported she would talk with her daughter. The other 3 residents felt like they were treated respectfully and had no concerns. None of the interviews were dated when they occurred or identified who asked the questions. The resolution section and follow-up comments on the grievance report were left blank. The administrator signed off the report on 3/5/26. There was no indication the administrator or DON acted per the facility policy on the alleged allegations of verbal abuse and involuntary and reported the allegations to the SA. Interview on 7/29/26 at 3:26 p.m. with regional clinical service director identified the grievance forms were missing information including a thorough			21980			

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21980	Continued from page 13 investigation of each grievance with follow up to the concerned party. She agreed that the facility should have acted upon that email and the grievances (allegations of verbal abuse and involuntary seclusion) should have resulted in the suspension of RN-A and the administration should have immediately started an investigation. She revealed in all the grievances reviewed from November and December 2025, there seemed to be a pattern of only interviewing the parties identified in the concern and agreed that further interviews should have been completed to ensure a thorough investigation had occurred. She further agreed that the resolution and follow-up with the party concerned was lacking in most of the reviewed grievances and should have been completed per facility policy to ensure a satisfactory resolution. Her expectation was that the facility would brainstorm to ensure all grievances were handled and resolved appropriately. She made no mention the grievances were allegations of verbal abuse and involuntary seclusion and should have been reported to the SA immediately. Interview on 7/30/26 at 8:07 a.m., with the administrator identified he felt the facility did start an investigation. The DON-A was to complete the investigation and that was why he had not participated in it. He reached out to DON-A who reported the concern. DON-A did educate RN-A but did not document that education. The facility completed interviews with residents last night (7/29/26) (nine after the incidents) and suspended RN-A while a new investigation was being conducted. He stated there was no verbal abuse identified and the situation “had been handled” as R27 had no concerns and there had been “no lasting effect, and no signs of psychosocial distress”. The administrator declined to answer if RN-A should have been suspended when the incidents occurred for R30 and R44 in order to potentially prevent further incidents with R27 and other residents. Review of the 4/7/25, Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy and Rehab policy identified the policy was created to ensure employees were knowledgeable regarding the reporting and investigative process of abuse and neglect allegations, and ensure an effective system was in place that prevented mistreatment, neglect and abuse. It was also designed to ensure a complete review by the investigative team was completed to identify allegations of abuse and neglect were promptly reported and investigated.			21980			

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21980	Continued from page 14 Allegations involving mistreatment, neglect, or abuse were to be reported immediately to the administrator in order to intervene and protect residents. With an allegation of employee to resident abuse, the employee was to be removed from providing direct care to all residents. And be placed on suspension pending the results of the investigation. Allegations were to be reported immediately but no later than 2 hours after the allegation was made. Allegations that did not involve abuse and had no serious bodily injury were to be reported no later than 24 hours after the allegation was made. The investigation team (social worker (SW), DON and administrator) were to review all events no later than the next working day following the event. The facility was to ensure someone was assigned to complete the investigation and the SW or designee was to notify the SA. The investigation was to include interviewing employees, residents and/or witnesses to the event, but made no mention of interviewing others not directly involved but who may have knowledge about other pertinent facts or data of incidents. The SW or designee was to report results of all investigations to the SA within 5 working days of the event. SUGGESTED METHOD OF CORRECTION: The administrator or designee should develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to those policies and procedures and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance and continue to be discussed at QAPI on a routine basis. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21980			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245455		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - JACKSON				STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON , JACKSON, Minnesota, 56143			
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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 07/28/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society - Jackson 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. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			08/27/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245455		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Good Samaritan Society - Jackson is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1956, is one-story, has no basement, and was determined to be of Type I(332) construction; The 1st Addition was constructed in 1965, is one-story, has no basement, and was determined to be of Type I(332) construction; The 2nd Addition was constructed in 1976, is one-story, has a partial basement, and was determined to be of Type I(332) construction; The 3rd Addition was constructed in 1996, is one-story, has no basement, and was determined to be of Type I(332) construction. The building is divided into six smoke compartments. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors and resident rooms that are monitored for automatic fire department notification.			K0000			08/27/2026

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K0000 Bldg. 01	Continued from page 2 The facility has a capacity of 46 beds and had a census of 36 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			08/27/2026
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection records and safety measures associated with cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.2.3. and NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations section 11.2.1 This deficient practice could have a widespread impact on the residents within the facility. Findings include: On 07/28/2026 at 9:18 AM, it was revealed by			K0324	The kitchen fire suppression system was last tested on 4/3/2026 the next test is scheduled in 10/2026 All residents have the potential to be affected by this deficient practice. Documentation was reviewed from last year to ensure proper testing was completed. To ensure systematic change, lead maintenance technician received education that the kitchen fire suppression system needs to be tested every six months To ensure compliance, 100% of kitchen fire suppression system test will be audited for the next year to ensure compliance with testing requirements. Findings will be brought to QAPI and Safety Committee to determine if further action is needed.		09/04/2026

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K0324 SS = F Bldg. 01	Continued from page 3 documentation review and staff interview that the facility was not inspecting the kitchen fire suppression system every six months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0324			09/04/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 7.3.1 and 8.3.8. This deficient finding could have a widespread impact on the residents within the facility			K0918	To fix deficient practice, a fuel quality test was completed and battery-operated light was installed. All residents have the potential to be affected by deficient practice; documentation was reviewed from year prior to ensure fuel quality test were completed. Lead Maintenance tech received education on the expectation that a fuel quality test must be completed annually, and a battery-operated light needs to be installed by generator switch. Administrator or designee will complete audits to ensure battery operated light is functioning weekly x4, monthly x3. 100% of fuel quality tests will be audited for 1 year to ensure they are completed to meet regulations. Findings will be brought to the Safety Committee and QAPI to determine if further action is needed.		09/04/2026

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K0918 SS = F Bldg. 01	Continued from page 4 Findings include: 1. On 07/28/2026 at 9:27 AM, it was revealed by a review of available documentation at the time of the survey that the facility could not provide documentation showing a fuel quality test had not been performed within the last year. 2. On 07/28/2026 at 10:30 am, it was revealed by observation that the emergency generator transfer switch room was not provided with a battery powered emergency light. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0918			09/04/2026
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty			K0923	To fix deficient practice full and empty oxygen tanks were organized in two separated crates Nursing staff received education on proper placement of oxygen tanks Signage was placed in oxygen room to clearly label where full and empty oxygen tanks should be placed. Administrator or designee will audit for proper placement of oxygen tanks weekly x4 monthly x3. Findings will be brought to QAPI and the Safety Committee to determine if further action is needed.		09/04/2026

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K0923 SS = F Bldg. 01	Continued from page 5 cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to store oxygen containers per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/28/2026 at 10:20 AM, it was revealed by observation that the oxygen containers in the oxygen storage room were not segregated from full and empty. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0923			09/04/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

September 23, 2026

Electronically delivered

CMS Certification Number (CCN):245455

Administrator

GOOD SAMARITAN SOCIETY - JACKSON
601 WEST JACKSON
JACKSON, MN 56143

Dear Administrator:

To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon achieving substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 4, 2026 the above facility is certified for:

46 Skilled Nursing Facility/Nursing Facility Beds

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

