



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 1, 2026

Administrator

GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE

745 BASINGER MEMORIAL DRIVE

MOUNTAIN LAKE, MN 56159

RE: CCN: 245549

Cycle Start Date: August 12, 2026

Dear Administrator:

On August 12, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.dahl@state.mn.us
Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 November 12, 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 February 12, 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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

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

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/11/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 08/11/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society - Mountain Lake 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			09/01/2026

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: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/11/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
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. Main Building of Good Samaritan Society Mountain Lake was constructed as follows: The original building was constructed in 1976, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 1995 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 2000 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The 2013 Link Addition. It is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. There are no resident sleeping or treatment areas located in Building 02. Main Building is separated from an assisted living			K0000			09/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/11/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
K0000 Bldg. 01	Continued from page 2 facility by a proper two-hour fire wall assembly.			K0000			09/01/2026
K0324 SS = E Bldg. 01	The facility has a capacity of 48 beds and had a census of 46 at the time of the survey.			K0324			09/28/2026
	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:						
K0324 SS = E Bldg. 01	Cooking Facilities			K0324	K-324-Cooking Facilities		
	CFR(s): NFPA 101						
	Cooking Facilities				The location will install paint, tape, or mechanical device to keep the stove in the correct place.		
	Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:				All moveable kitchen cooking equipment will be checked to ensure NFPA compliance.		
	* 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				The dietary and maintenance staff will be trained in proper placement of appliances under the Ansul system.		
	* 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				Audits of the placement of the appliances under the Ansul system will be completed by the Administrator or Designee weekly x 4, monthly x2. Audits will be reviewed by the QAPI committee.		
	* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.				Substantial completion will be achieved by 9/28/2026.		
	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 observation and staff interview, the facility failed to maintain 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 12.1.2.3 and 12.1.2.3.1. This deficient practice could have a patterned impact on the residents within the facility.							
Findings include:							
On 08/11/2026 at 10:07 AM, it was revealed by							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/11/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
K0324 SS = E Bldg. 01	Continued from page 3 observation and staff interview that the kitchen fire suppression system did not have an approved method to ensure that the appliance is returned to an approved design location. An interview with the Maintenance Mechanic verified this deficient finding at the time of discovery.			K0324			09/28/2026
K0353 SS = E Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2(5), and 5.2.2.2. This deficient finding could have an patterned impact on residents within the facility. Findings include: On 08/11/2026 it was revealed by observation that the sprinklers in the kitchen and dishwashing areas were not free from corrosion and foreign materials. An interview with the Maintenance Mechanic and			K0353	K-353- Sprinkler System Maintenance and Testing. The sprinkler heads in the kitchen and dishwashing areas will be replaced. All sprinkler heads will be checked to make sure they are free of debris and corrosion. Training will be conducted with staff on the importance of keeping sprinkler heads free of debris and corrosion. Audits of sprinkler heads will be completed weekly x 4, monthly x2 be the Administrator or designee. Audits will be reviewed by the QAPI committee. Substantial completion will be achieved by 9/28/2026.		09/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/11/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
K0353 SS = E Bldg. 01	Continued from page 4 Administrator verified this deficient finding at the time of discovery.			K0353			09/28/2026
K0511 SS = E Bldg. 01	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to secure gas appliances per NFPA 101 (2012 edition), Life Safety Code, section 9.1.1, and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.6.1.2. and 10.12.6. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/11/2026 at 10:07 AM, it was revealed by observation that the gas appliance in the kitchen was on casters and not secured. An interview with the Maintenance Mechanic verified this deficient finding at the time of discovery.			K0511	K- 511- Utilities – Gas Electric The kitchen equipment that is designated to be under the kitchen hood/Ansul system will have devices attached to be secured according to NFPA requirements. The kitchen equipment that is designated to be under the kitchen hood/Ansul system will have devices attached to be secured according to NFPA requirements. Training will be conducted with kitchen and maintenance staff on the NFPA requirements for kitchen equipment. Audits of the kitchen equipment will be conducted by the Administrator or designee weekly x 4, monthly x2. Audits will be reviewed by the QAPI Committee. Substantial completion will be achieved by 9/28/2026.		09/28/2026
K0761 SS = E Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are			K0761	K-761-Maintenance, Inspection and Testing -Doors. The rolling doors will be tested by the vendors to maintain compliance with NFPA requirements. The fire alarm panel schedule will be checked to make sure the fire panel vendors are testing the rolling doors on a schedule that will maintain compliance with NFPA compliance. Training on the NFPA requirements for the rolling doors will be completed with the maintenance staff. Audits of the documentation for the rolling door test will be completed by the Administrator or designee weekly x 4, monthly x 2.		09/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/11/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
K0761 SS = E Bldg. 01	Continued from page 5 maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/11/2026 at 9:02 AM, it was revealed by a review of available documentation and staff interview that the three roll doors in the facility had not been inspected annually. An interview with the Maintenance Mechanic verified this deficient finding at the time of discovery.			K0761	Continued from page 5 Substantial completion will be achieved by 9/28/2026		09/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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 8/10/26 through 8/12/26, 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			09/01/2026
F0000	INITIAL COMMENTS On 8/10/26 through 8/12/26, a standard recertification survey (S5549042-0) 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: H55493273C (3075679). 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. The facility is enrolled in ePOC, 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, the facility must acknowledge receipt of the			F0000			

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: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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	
F0000	Continued from page 1 electronic documents.		F0000			09/01/2026	
F0755 SS = E	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 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 observation, interview, and document review, the facility failed to reconcile liquid controlled narcotic medications in 1 of 2 medication cart to prevent potential diversion for 5 sampled residents (R7, R8, R26, R36, and R53). Findings include: Observation and interview on 8/11/26 at 2:13 p.m., with registered nurse (RN)-B and licensed practical nurse (LPN)-A as they completed the change of shift		F0755	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitute the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F 755 – Pharmacy services What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Upon identification of the concern, the DNS reviewed the controlled-substance accountability process for the medication cart identified during the survey and the controlled liquid medications and corresponding controlled substance records for the identified residents (R7, R8, R26, R36, and R53) on the affected medication cart. The consultant pharmacist was contacted regarding the liquid controlled medications and the availability of appropriate containers for accurate measurement. The controlled medications, medication administration records, controlled-substance records, and remaining medication quantities were reconciled to determine that the medications were accurately accounted for and there was no evidence of diversion. Liquid controlled medications requiring appropriate graduated measurement markings were transferred/repackaged by the pharmacy into appropriate containers with graduated markings and appropriately labeled. The DNS reviewed the controlled-substance shift to shift-count process with the nurses assigned to the affected medication cart and reinforced that all liquid controlled substances must be physically measured and reconciled at every change of shift, rather than relying solely upon the medication bottle or visual estimation. How will other residents, having the potential to be affected by the same deficient practice, be		09/11/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
F0755 SS = E	Continued from page 2 narcotic count. RN-B counted the narcotic pills located in the medication cart locked box while LPN-A confirmed the count. RN-B finished with the narcotic pills and proceeded to shut and lock the lock box located in the medication cart and then lock the medication cart. RN-B did not pick up or confirm the amount of 7 bottles of liquid narcotic medications also located in the locked box. RN-B stated, “we don’t count morphine as it is “hard to tell as a liquid”, RN-B did confirm the facility documented in the narcotic book when they administered the liquid narcotic medications. Located in the locked box within the medication cart that was not reconciled was: R7’s Morphine liquid 20 milligram (mg)/per milliliter (ml), 21.5 ml R8’s Morphine liquid unknown strength, 24 ml R23’s Morphine liquid 20 mg/ml, 28.25 ml R26’s Codeine liquid solution, 68 ml R36’s Morphine liquid 100mg/5ml, 23.5 ml R36’s Morphine liquid100mg/5ml (2nd bottle), 25.75 ml R53’s Lorazepam liquid solution, 30 ml LPN-A confirmed that the facility had not been verifying the liquid narcotic medication. Interview on 8/11/26 at 2:20 p.m., with RN-C reported all the narcotics should be reconciled including the liquid narcotics. Everything that was in that locked box should be counted to confirm the correct amount remained. Interview on 8/11/26 at 2:22 p.m., with RN-A confirmed all narcotics should be counted shift to shift to verify the amount. She would expect that each nurse completed narcotic counting would be checking all controlled medications. Interview on 8/11/26 at 2:57 p.m., with director of nursing (DON) identified nurses should be counting all narcotics shift to shift between 2 staff. Liquid narcotics should be counted even though they can be hard to count. She was not aware that the nurses were not counting the liquid narcotics and stated, “I wonder how long they have not been doing that”.			F0755	Continued from page 2 identified? All residents have the potential to be affected by this deficient practice. The DNS/designee conducted an audit of all medication carts and medication storage areas containing controlled substance and liquid controlled substance medications. The audit included verification of 100% controlled medications, the medication name, strength, quantity remaining, and accurate method for measuring the medication, along with controlled-substance records with medication administration records, and shift-to-shift reconciliation. Any liquid controlled medication identified without an appropriate method for accurate measurement was referred to the pharmacy for correction and relabeling before continued use. Any discrepancy was investigated and reported to the appropriate individuals in accordance with facility policy and procedures. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic change is maintained, the DNS/designee will educate all licensed nurses and Trained Medication Assistants on the Policy and Procedure on Medications: Controlled. Education on being responsible for medication administration and controlled-substance counts regarding the shift to shift controlled-substance accountability procedure. Education will include, requirement to count all controlled substances, Including liquid controlled substances with every count, accurate measurement of liquid controlled substances, reconciliation of the physical medication with the controlled-substance record, review of medication administration documentation, proper completion of controlled-substance count documentation, procedure for identifying and reporting discrepancies, and procedure for obtaining an appropriate container/measurement device when one is not available. Any licensed nurse who does not complete the required education will not independently perform controlled substance counts until education has been completed. Newly hired licensed nurses will receive the education during orientation before independently performing controlled substance counts.		09/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
F0755 SS = E	Continued from page 3 She confirmed that staff are to count each narcotic medication liquid or pill to confirm amount. Interview on 8/12/26 at 11:21 a.m., with regional clinical service director identified she would expect that the facility was reconciling all controlled medications shift to shift to monitor for diversion. Staff should be taking each medication out of the locked box and verifying the count including the liquid medication. Interview on 8/12/26 at 1:48 p.m., with consulting pharmacist identified she would have expected that the facility staff would be reconciling all controlled medication. She revealed she did quarterly medication pass audits; however, was not usually there at time of narcotic count between shifts but when she was there, she would review the narcotic book. She would expect a system to be in place to count and monitor all controlled medications for potential diversion. Review of the 6/30/26, Medications: Controlled policy identified reconciliation was a system to monitor controlled medication. All controlled medication would be verified when delivered and documented in the bound narcotic record book. Each time the keys that secured the controlled medication locked box the oncoming and off-going nurse/medication aide would reconcile all the controlled medications to ensure the count matched the remaining amount listed.			F0755	Continued from page 3 How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is sustained, DNS/designee will complete an audit of controlled substances accountability weekly X4 weeks and monthly X3 months. DNS/designee will also visually monitor for proper shift to shift counting of controlled substances and will verify that the physical quantity has graduated markings and recorded on the controlled substance record. Audit results will be reported to QAPI for review and continued monitoring. What is the date of completion? 9/18/26		09/11/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident.			F0628	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitute the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F 625 – Discharge Process What corrective action will be accomplished for those residents found to have been affected by the		09/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
F0628 SS = D	Continued from page 4 (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;			F0628	Continued from page 4 deficient practice? R49's discharge to The Lodge has been reported to the Office of Ombudsman on the August 2026 report. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents who transferred or discharged from the facility have the potential to be affected. The Social Worker/designee reviewed the Hospital Transfer Log and PCC Action Summary Report for the previous 90 days to identify all resident transfers and discharges and compared these records to the Monthly Notices submitted to the Office of the State Long-Term Care Ombudsman. Any omitted notifications identified through the review were submitted to the Ombudsman. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, the Social Worker, DON, and designated backup were educated on the Policy Discharge and Transfer and regarding the requirement to notify the Office of the State Long-Term Care Ombudsman of all resident transfers and discharges regardless of destination. The Social Worker/designee will add resident transfers and discharges to the Monthly Notice as they occur. At the end of each month, the Social Worker/designee will compare the Monthly Notice with the Hospital Transfer Log and PCC Action Summary Report to verify all required transfers and discharges are included prior to submission. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained, the QAPI Coordinator/designee will audit compliance monthly x3 and quarterly for one additional quarter. The audit will compare the Hospital Transfer Log and PCC Action Summary Report to the Monthly Notice submitted to the Office of the State Long-Term Care Ombudsman to verify that 100% of required resident		09/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
F0628 SS = D	Continued from page 5 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.			F0628	Continued from page 5 transfers and discharges were reported. Any omissions will be corrected promptly and addressed with the appropriate staff. Audit results will be brought to the QAPI committee for review and further recommendations. What is the date of completion? 9/11/26		09/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
F0628 SS = D	Continued from page 6 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is			F0628			09/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
F0628 SS = D	Continued from page 7 not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to notify the ombudsman of 1 of 2 (R49) sampled resident discharges. Findings include: R49's 6/17/26, accepted discharge Minimum Data Set (MDS) assessment identified R49 was discharged to his home/community with return not anticipated. R49's 6/25/26, discharge summary identified he was independent with activities of daily living (ADLS) following completion of skilled physical and occupational therapies. His cognition was intact, and the decision was made to transfer to Assisted Living following discharge. Interview on 8/11/26 at 10:29 a, m. with registered nurse (RN)-D reported R49 had originally transferred from the Windom facility where he was originally admitted following hospitalization. He was admitted for skilled therapies, and following completion he and his family made the decision to discharge to the local Assisted Living facility. Interview on 8/12/26 at 8:09 a.m. with the director of nursing (DON) and licensed social worker (LSW) identified they were not aware the ombudsman was supposed to be informed when residents voluntarily discharged to the community, and as a result had not done so.			F0628			09/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
F0628 SS = D	Continued from page 8 Email response on 8/12/26 at 10:36 a.m. from the Ombudsman reported she had reviewed documentation she had received from the facility, and she was only being informed of residents that went to the hospital. She identified she should have been notified of all resident discharges and transfers regardless of the destination. Interview on 8/12/26 at 1:02 p.m. with the administrator reported she was not aware appropriate notifications of transfers or discharges were not being provided to the Ombudsman. She identified her expectations for the notification requirements to be followed. Review of January 15, 2026, Discharge and Transfer policy identified when a resident was transferred or discharged, the location must send a notification to the Office of the State Long-Term Care Ombudsman.			F0628			09/11/2026
F0880 SS = D	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 §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:			F0880	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitute the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F 880 – Infection Prevention & Control What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Facility was using the Absence Tardy Report form for reporting employee absences and tardiness; however, was-not consistent to include follow-up documentation when an employee reported symptoms potentially associated with an infectious illness. When employees reported symptoms of possible infectious illness in nature, documentation was not consistently present to demonstrate that the employee had been assessed for infectious illness		09/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
F0880 SS = D	Continued from page 9 (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. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure employee illnesses were tracked to identify when employee would be able to return to work after an illness, depending upon their			F0880	Continued from page 9 and determined to be safe to return to work. Facility implemented an Employee Illness/Return-to-Work Assessment process for any employee reporting symptoms that may represent an infectious illness. When an employee calls off, the employee will be asked about symptoms, onset and duration of symptoms. For employees reporting symptoms which may be infectious in nature, all department managers will be aware of informing the IP/DNS or designee of symptoms reported. IP/DNS or designee will determine whether the employee should remain off duty and when the employee may safely return to work based on current facility policy, and/or public health guidance. The assessment and return-to-work determination will be documented on the Employee Illness/Return-to-Work Assessment form. Employees will not be permitted to return to resident care until the required assessment has been completed and the employee has been determined to be safe to return to work. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be affected by this deficient practice because all employees may report illness or symptoms that could represent a communicable disease. The facility will review the previous 90 days, plus LPN-A and NA-B from March and June cited in the survey. employee illness/absence reports to identify employees who reported potentially infectious symptoms and determine whether appropriate follow-up and return-to-work documentation was completed. Any identified employee record lacking the required assessment will be reviewed by the IP/DNS or designee, and appropriate follow-up will be completed as applicable. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Measures put in place. All staff were educated on the Policy and Procedure: Infection Prevention and Control Program and the Policy and Procedure: Employee Health Conditions Reporting and Managing Infection Control. Shown the Absence Tardy Report form used and, on the documentation, needed when an Employee calls off. All Department		09/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
F0880 SS = D	Continued from page 10 symptoms for 2 of 3 sampled staff (nursing assistant (NA)-B with gastrointestinal illness. 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/ltcfnorotoolkit.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 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).			F0880	Continued from page 10 Managers were educated to inform IP/DNS or designees of symptoms of infectious illness in nature and if employees need to be off an extended period. Taught on when an employee returns to work, they will need to report to a licensed staff nurse who will fill out the bottom portion of the Absence Tardy Report Form to ensure employee is clear to return to work. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? The IP/DNS or designee will conduct audits on all potentially infectious employee illness episodes during each interval, weekly for 4 weeks and monthly for 3 months. Verifying: Symptoms and onset were documented. Appropriate work restrictions were followed. Symptom-resolution date and time were documented. Applicable return-to-work criteria were met. Clearance was documented before the employee resumed duties, confirmed against schedules/time records. Ensuring Absence Tardy Report form was filled out correctly and employees with symptoms of infectious nature followed proper procedures per policy. Results will be reported to QAPI committee for review and continued monitoring. What is the date of completion? 9/18/26		09/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
F0880 SS = D	Continued from page 11 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 where they may expose people to norovirus. Review of the March 2026 through June 2026, Employee Absence Tardy Report, Employee Call out logs, and comparative timesheets identified:			F0880			09/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
F0880 SS = D	Continued from page 12 LPN-A was noted to have called in to work with symptoms of diarrhea (loose watery stool) on 3/21/26. LPN-A reported to be absence/tardy on 3/22/26. Employee timesheets identified LPN-A returned to work on 3/24/26. There was no indication LPN-A had been screened prior to coming back to work to ensure they had been removed from patient contact for 48-72 hours after symptoms resolved. NA-B was noted to have called in to work with symptoms of nausea, vomiting and diarrhea on 6/20/26. NA-B was reported to be absence/tardy on 6/20/26 with symptoms of a sore throat, nausea, vomiting, and diarrhea. Employee timesheets identified NA-B returned to work on 6/21/26. There was no indication NA-B had also been screened prior to coming back to work to ensure they had been removed from patient contact for 48-72 hours after symptoms resolved. Overall, there was no mention on the Absence/Tardy Reports when or if LPN-A or NA-A's symptoms resolved prior to returning to work. The section at the bottom of the report sheet to identify if an employee was clear to work was left blank. Interview on 8/12/2026 at 11:52 a.m., with registered nurse (RN)-C, who is the Infection Preventionist (IP) revealed both director of nursing (DON) and IP tracked employee call outs and illnesses electronically. She acknowledged she provided oversight and did not implement appropriate monitoring of employee illnesses when they occur. Interview on 8/12/2026 at 12:50 p.m., with DON stated the employee Absence/Tardy Report sheet was used to track employee illnesses at the facility. She acknowledged the sheet should have been filled out appropriately to determine whether an employee illness was resolved and/or if it was clear for the staff to return to work. Review of 9/23/25 Employee Health Conditions Reporting and Managing, Infection Control-Rehab/Skilled, Senior Living policy identified the administrator, or designee was responsible to ensure supervisors and staff were trained and understand the importance of reporting and managing employee illness and symptoms. Employees were to consult their supervisor to evaluate the condition and consult the IP, if available. Employees returning after an illness were			F0880			09/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159			
(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
F0880 SS = D	Continued from page 13 to consult their supervisor and the supervisor may involve clinical members, such as the IP, DON, or a licensed nurse. Review of 3/25/26 Identification/Surveillance, Management, and Reporting of Suspected/Confirmed Infections, AL, R/S, LTC, Home Health, Hospice policy identified the IP or appointed designee, was to review additional information to identify indicators of infection, collect data to confirm/suspected infections, such as employee illness records to determine disease and/or outbreak reporting requirements.			F0880			09/18/2026