Electronically Delivered

July 14, 2022

Administrator
Good Samaritan Society - Bethany
1953 7th Street South
Brainerd, MN 56401

RE: Project Number SL30420015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 23, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

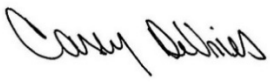
Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

(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) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30701015-0 On June 21, 2022, through June 23, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were thirty-eight (38) residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19. The licensee failed to ensure staff wore recommended personal protective equipment while working in the facility and failed to Covid-19 screen prior to providing direct care to residents. The deficient practice had the potential to affect all residents, employees and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 510		

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0 510	Continued From page 2 EYE PROTECTION On June 21, 2022, at 10:00 a.m., a surveyor from the Minnesota Department of Health (MDH) entered the facility and was greeted at the door by clinical nurse supervisor (CNS)-B. CNS-B wore a medical grade mask and prescription eyeglasses. No protective eyewear was worn by CNS-B. The surveyor completed Covid-19 screening via electronic temperature monitor and electronic surveillance at the entrance door. While the surveyor was completing the entrance screening, a visitor entered through the same door, walked through the hallway and entered a resident room without screening. Licensed assisted living director (LALD)-A On June 21, 2022, at approximately 10:45 a.m., during the entrance conference with LALD-A and throughout the remainder of the day, the surveyor observed LALD-A wore a medical grade mask and no protective eyewear throughout interactions with staff, the surveyor, nor while walking throughout resident communal areas, hallways, elevators and dining room. On June 21, 2022, at approximately 11:52 a.m., the surveyor toured the facility with LALD-A, and no protective eyewear was worn by LALD-A. Unlicensed personnel (ULP)-E On June 21, 2022, at approximately 11:58 a.m., during the tour of the facility, the surveyor observed ULP-E preparing lunch and gathering supplies on the 1st floor in the common dining room with numerous residents present. The surveyor observed ULP-E lacked the use of protective eyewear. ULP-F On June 21, 2022, at approximately 11:58 a.m.,	0 510		

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0 510	Continued From page 3 during the tour of the facility, the surveyor observed ULP-F preparing lunch and gathering supplies on the 1st floor in the common dining room with numerous residents present. The surveyor observed ULP-F lacked the use of protective eyewear. STAFF COVID-19 SCREENING ULP-F On June 21, 2022, at approximately 1:10 p.m., the surveyor reviewed staff Covid-19 screening logs provided by LALD-A. ULP-F had not completed Covid-19 screening prior to her 6:00 a.m. to 2:00 p.m. shifts on June 20, 2022 and June 21, 2022. During an interview on June 21, 2022, at 1:21 p.m., LALD-A confirmed the lack of protective eyewear use for ULP-E, ULP-F and CNS-B and of all staff providing direct resident cares. LALD-A stated the campus director of nursing emailed updates weekly on the community transmission levels of Covid-19 to LALD-A and most recently indicated the level for the county was low. The surveyor confirmed with CNS-B and LALD-A the link to the Centers for Disease Control and Prevention (CDC) website for knowledge of community transmission levels and required personal protective equipment (PPE) use. LALD-A stated they reviewed the link with administrator (A)-D and confirmed the county level to be high. The Minnesota Department of Health (MDH) COVID-19 PPE and Source Control Grids for Congregate Care Settings by Community Transmission Levels dated April 7, 2022, indicated with high community transmission levels, protective eyewear and medical grade	0 510		

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0 510	Continued From page 4 masks were to be worn by staff to prevent unseen spread of COVID-19 in a facility. The guidance recommended eye protection when staff were in resident care areas. On June 21, 2022, at approximately 1:25 p.m., the surveyor, LALD-A and CNS-B confirmed the Centers for Disease Control and Prevention (CDC) county tracker indicated covid transmission levels were high within the county the facility is located. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information to include: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; and	0 640		

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0 640	Continued From page 5 (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living and the information for reporting suspected maltreatment to MAARC. On June 21, 2022, at approximately 11:52 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and observed the common areas lacked the required posting for the 911 emergency number and the reporting number for MAARC. LALD-A confirmed 911 number and MAARC information was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records	0 650		

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0 650	Continued From page 6 (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee records contained the required content for two of two employees (unlicensed personnel (ULP)-E and ULP-F), with records reviewed.	0 650		

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0 650	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E ULP-E had a hire date of June 29, 2010, and began providing services under the licensee's Assisted Living license on August 1, 2021. ULP-E's record lacked 2020 and 2021 annual performance reviews that identified areas of improvement needed and training needs. ULP-F ULP-F had a hire date of August 24, 2010, and began providing services under the licensee's Assisted Living license on August 1, 2021. ULP-F's record lacked 2020 and 2021 annual performance reviews that identified areas of improvement needed and training needs. On June 22, 2022, at approximately 2:20 p.m., licensed assisted living director (LALD)-A confirmed ULP-E and ULP-F employee records lacked an annual performance evaluation, as required. Additionally, LALD-A stated, "that was during Covid, and we were told we didn't need to do them." No further information was provided.	0 650		

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0 650	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff.	0 780		

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0 780	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 21, 2022, between 11:00 a.m. and 12:55 p.m., survey staff toured the facility with the director of maintenance (DM)-C. During the facility tour, survey staff observed that smoke alarms were not installed in the bedrooms of apartments 202, 302, 308, and 314. During the tour interview, the DM-C confirmed that smoke alarms were not provided within some of the apartment bedrooms. The DM-C explained that the facility was still in the process of adding bedroom smoke alarms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800		

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0 800	Continued From page 10 by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 21, 2022, between 11:00 a.m. and 12:55 p.m., survey staff toured the facility with the director of maintenance (DM)-C. During the facility tour, survey staff observed the following: 1. The electrical and fire sprinkler rooms were being used for storage. Carts and vacuum cleaners obstructed the electrical panels. Items within the fire sprinkler room had to be removed before survey staff could enter this space. 2. The carpet in one bedroom of resident apartment 211 was soiled. 3. The bathroom vent cover was dusty in apartment 314. During the tour interview, the DM-C confirmed that items should not be stored in a manner that blocks access to the electrical panels or fire sprinkler room. They also confirmed that the bedroom carpet in apartment 211 was stained and that the bathroom vent cover in apartment 314 required cleaning. 4. The hallway carpet on the third floor had a few spots where it was torn, creating a potential trip/fall hazard.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

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0 800	Continued From page 11 On June 21, 2022, at approximately 2:15 p.m., during an interview with the licensed assisted living director (LALD)-A, it was confirmed that the hallway carpet required repair. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	0 810		

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	30420	A. BUILDING: _____ B. WING _____	06/23/2022

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0 810	Continued From page 12 (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide the required plans, training, and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 21, 2022, between 11:00 a.m. and 12:55 p.m., survey staff toured the facility with the director of maintenance (DM)-C. During the facility tour, survey staff observed that the location and number of resident sleeping rooms were not legible on the evacuation map posted on the first floor of the facility. In an interview with DM-C during the tour, they confirmed that the resident room numbers were not clearly labeled on the first-floor evacuation map. On June 21, 2022, at approximately 1:00 p.m., the licensed assisted living director (LALD)-A and the DM-C provided documents for review. Documents were reviewed by survey staff on June 21, 2022, between 1:00 p.m. and 2:00 p.m.	0 810		

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	30420	A. BUILDING: _____ B. WING _____	06/23/2022

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0 810	Continued From page 13 1. The plans failed to include the identification of unique or unusual resident needs for movement or evacuation. 2. The licensee failed to provide the required employee training frequency. Employee training for fire safety and evacuation was completed at the time of hire and then annually using an online educational program. The licensee failed to provide documentation supporting the required employee training frequency for the facility fire safety and evacuation plans. 3. Fire drill logs were provided for review. An evacuation drill was not completed in December 2021 or January 2022. The licensee failed to meet the every other month frequency requirement. On June 21, 2022, at approximately 2:15 p.m., the LALD-A confirmed during an interview that the facility failed to provide the required content within the fire safety and evacuation plans. They also confirmed that the training and drill frequency were not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is	0 970		

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	30420	A. BUILDING: _____ B. WING _____	06/23/2022

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0 970	Continued From page 14 required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 and R2's Senior Living Occupancy Agreement Assisted Living contract dated July 29, 2021, and R3's Senior Living Occupancy Agreement Assisted Living contract dated July 21, 2021, each contained a paragraph clause indicating the resident would waive the facility's liability as follows: "[facility name] is not liable for loss or damage by fire, theft, or other casualty, nor injuries from the use of the UNIT to TENANT, personal possessions, family, or any guest or invitee of TENANT. Any insurance necessary or desired by TENANT shall be at TENANT's expense." Page 6, item A under heading Rights and Responsibilities of Bethany. On June 23, 2022, at approximately 10:55 a.m.,	0 970		

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	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 970	Continued From page 15 administrator (A)-D confirmed R1, R2 and R3's Senior Living Occupancy Agreement Assisted Living contract included the waiver of liability, and the same assisted living service agreement was used for all residents at the facility. No further information available. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered	01730		

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	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 16 nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of two residents (R2, R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on June 21,	01730		

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	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

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01730	Continued From page 17 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services for the licensee's residents. R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD), seizures and diabetes type II. R2's service plan dated June 21, 2022, indicated R2 received medication management services four (4) times daily. R2's EMAR dated June 2022, included the following medications: one antiseizure, one blood thinner, three blood pressure reducers, one stomach acid reducer, one diuretic, four vitamin supplements, one mild pain reliever, one cholesterol reducer, two insulins, one antiurinary retention and two inhalers. On June 22, 2022, at 8:13 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R2's morning medications. R1 R1's diagnoses included COPD and hypertension (elevated blood pressure). R1's service plan dated June 21, 2022, indicated R1 received medication management services three (3) times daily. R1's electronic medication administration record (EMAR) dated June 2022, included the following medications: two bladder maintainers, one thyroid medication, one stomach acid reducer, one diuretic, one blood thinner, one nerve pain reducer, one blood pressure reducer, one stool	01730		

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	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 18	01730		

softener, one cholesterol reducer, one topical pain reducer, one antidepressant, five vitamin supplements and two inhalers.

On June 22, 2022, at 9:03 a.m., the surveyor observed ULP-F administer R1's morning medications.

R1 and R2 lacked an individualized medication management plan to include the following:
- a statement describing the medication management services that will be provided;
- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;
- documentation of specific resident instructions relating to the administration of medications;
- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;
- identification of medication management tasks that may be delegated to unlicensed personnel;
- procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and
- any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

On June 23, 2022, at approximately 10:30 a.m., LALD-A and clinical nurse supervisor (CNS)-B confirmed R1 and R2's record did not include individualized medication management plans with all the required content. Additionally, CNS-B stated, "I've been losing sleep over this. We do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 19 not have all the requirements set up." The licensee's medication management policies did not address the development or implementation of an individualized medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=E	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication setup was completed at the time of setup and included all the required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	01770		

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	30420	A. BUILDING: _____ B. WING _____	06/23/2022

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01770	Continued From page 20 found to be pervasive). The findings include: During the entrance conference on June 21, 2022, at approximately 10:50 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided medication management services to include medication setup. R1 R1's diagnoses included COPD and hypertension (elevated blood pressure). R1's service plan dated June 21, 2022, indicated R1 received medication management services three (3) times daily. R1's electronic medication administration record (EMAR) dated June 2022, and confirmed with the med reconciliation in point-click-care (PCC) dated June 2022, included the following medications: - ascorbic acid 1 gram (g) daily; - betamethasone diproprionate 0.05% twice daily; - citalopram 20 mg daily; - ferriys sykfate 325 milligram (mg) daily; - i-vite vitamin daily; - biofreeze 4% topical twice daily; - levothyroxine 75 microgram (mcg) daily; - methenamine daily; - metoprolol 25 mg daily; - omeprazole 40 mg daily; - potassium chloride extended release (ER) 20 millequivalent (mEq) three times daily; - torsemide 80 mg twice daily; - vitamin D 100 mcg twice daily; - gabapentin 300 mg three times daily; - asmanex two puffs daily; - apixaban 5 mg twice daily; - Incruse Elipta 62.5 mcg/inhale one time daily;	01770		

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	30420	A. BUILDING: _____ B. WING _____	06/23/2022

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GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

(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) COMPLETE DATE
01770	Continued From page 21 - magnesuim 400 mg twice daily; - calcium 500 mg daily; and - Toviaz 8 mg daily. R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD), seizures and diabetes type II. R2's service plan dated June 21, 2022, indicated R2 received medication management services four (4) times daily. R2's EMAR dated June 2022 and confirmed with the med reconciliation in PCC dated June 2022, included the following medications: - levetiracetam 500 mg twice daily; - amlodipine 10 mg daily; - aspirin 81 mg daily; - ferrous sulfate 325 mg daily - magnesium oxide 400 mg twice daily; - potassium chloride 20 mEQ daily; - metoprolol succinate 25 mg daily; - Spiriva 18 mcg inhale one time daily; - omeprazole 20 mg twice daily; - clonidine 0.1 mg daily; - torsemide 40 mg daily; - losartan 100 mg daily; - vitamin D 1000 mg daily; - Humalog 3 units three times daily; and - acetaminophen 500 mg up to four times daily. On June 23, 2022, at 9:49 a.m., clinical nurse supervisor (CNS)-B stated, "Is that required? Ok, I can tell you, I don't have that. I don't document anything. I set them [med caddies] up in their rooms." CNS-B was referring to the request by surveyor for documentation of med caddie (a medication storage container that is divided into compartments organized by the days of the week	01770		

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	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

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01770	Continued From page 22 and times of the day) set up to be administered by unlicensed personnel (ULP). R1 and R2's records lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, licensee failed to date time-sensitive medications with an opened-on date for two of two residents (R2, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

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01890	Continued From page 23 situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on June 21, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services for the licensee's residents. R2 On June 22, 2022, at approximately 8:13 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R2 with administration of R2's Spiriva and Ventolin aerosol inhalers. R2's Spiriva aerosol inhaler 18 microgram (mcg) inhaler and Ventolin inhaler 120 mcg lacked labels to indicate the date opened by staff and removed from the pouch and when the inhalers would expire. The Expiration Guidelines for Inhalation Products dated July 2013, directed for the Ventolin inhaler to be discarded twelve months after removal from the foil tray. R1 On June 22, 2022, at 9:03 a.m., the surveyor observed ULP-F assist R1 with administration of R1's Asmanex 120 mcg inhaler. R1's Asmanex 120 mcg inhaler lacked a label to indicate the date staff opened the inhaler from the box and when the inhaler would expire. The manufacturer's instructions dated June 2021 for the use of the Asmanex inhaler, directed for the inhaler to be discarded 45 days after being	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

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01890	Continued From page 24 opened. On June 23, 2022, at approximately 10:40 a.m., clinical nurse supervisor (CNS)-B confirmed all time sensitive medications including the above noted time sensitive medications should be dated after opening with an open date and expiration date. Additionally, CNS-B stated, "I just sent another memo out to staff on labeling and dating." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

(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) COMPLETE DATE
01940	Continued From page 25 services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop individual treatment management plans with all required content for two of two residents (R2, R1) who received ordered treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on June 21, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided treatment and therapy services to residents. R2 R2's diagnoses included chronic obstructive	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

(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) COMPLETE DATE
01940	Continued From page 26 pulmonary disease (COPD), seizures and diabetes type II. R2's service plan dated June 21, 2022, indicated R2 received treatment services to include blood sugar checks four (4) times daily. On June 22, 2022, at approximately 8:23 a.m., the surveyor observed unlicensed personnel (ULP)-E check R2's blood sugar level with a result of 153 milligrams per deciliter (mg/dl). R1 R1's diagnoses included COPD and hypertension (elevated blood pressure). R1's service plan dated June 21, 2022, indicated R1 received treatment services to include assistance with application and removal of Tubigrips to both legs daily (compression stockings for the treatment of edema/fluid buildup in the legs). On June 22, 2022, at approximately 9:03 a.m., the surveyor observed ULP-F apply lotion and Tubigrips to R1's legs. R1 and R2's record lacked an Individualized Treatment and Therapy plan to include the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatment or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; and - any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

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01940	Continued From page 27 was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions. On June 23, 2022, at approximately 10:50 a.m., clinical nurse supervisor (CNS-B) confirmed R1 and R2's Individualized Treatment and Therapy Plans lacked the above noted requirements. The licensee's Treatment and Therapy Management Services did not address individualized treatment and therapy plans. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatments or therapies were administered as prescribed, or to document the reason they were not provided to	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

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01960	Continued From page 28 meet the resident's needs for two of two (R2, R1) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD), seizures and diabetes type II. R2's service plan dated June 21, 2022, indicated R2 received treatment services to include blood sugar checks four (4) times daily. On June 22, 2022, at approximately 8:23 a.m., the surveyor observed unlicensed personnel (ULP)-E check R2's blood sugar level with a result of 153 milligrams per deciliter (mg/dl). R2's Treatment Administration Record for June 2022, indicated R2's treatment record lacked documentation of completed treatments for the following dates and times: Blood Glucose checks missing in June: 8:00 a.m. - 6, 10, 19, 20, 21; 12:00 p.m. - 6, 8, 10, 19, 20; 5:00 p.m. - 6, 9, 10, 11, 12, 14, 16, 18, 19, 20; and	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

(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) COMPLETE DATE
01960	Continued From page 29 8:00 p.m. - 6, 9, 10, 11, 12, 14, 16, 18, 19, 20, 2022. R1 R1's diagnoses included COPD and hypertension (elevated blood pressure). R1's service plan dated June 21, 2022, indicated R1 received treatment services to include assistance with application and removal of Tubigrips to both legs daily (compression stockings for the treatment of edema/fluid buildup in the legs). On June 22, 2022, at approximately 9:03 a.m., the surveyor observed ULP-F apply lotion and Tubigrips to R1's legs. R1's Treatment Administration Record for June 2022 indicated R1's treatment record lacked documentation of completed treatments on the following dates and times: Tubigrips application and removal for June 2022: a.m. application - 10, 11, 12, 20; and p.m. removal - 5, 6, 9, 10, 11, 12, 14, 16, 18, 19, 20, 21, 2022. Skin Care lotion application prior to applying Tubigrips: a.m. - 10, 11, 12, 20, 2022 On June 23, 2022, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-B confirmed treatment documentation lacked for R1 and R2 on the above noted dates and times. The licensee's Treatment and Therapy Management Services - Minnesota dated May 13, 2022, indicated documentation of treatments and	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

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01960	Continued From page 30 therapies would be completed in the resident's treatment record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *06/21/22*
Time: 11:00:00
Report: 1017221104

Food and Beverage Establishment Inspection Report

Location:
Good Samaritan Society - Betha
1953 7th Street South
Brainerd, MN56401
Crow Wing County, 18

Establishment Info:
ID #: 0039375
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188291407
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114A ** Priority 1 **

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

LACTIC ACID SANITIZER MEASURED 0 PPM, MAINTAIN BETWEEN 700-1800 PPM.

Comply By: 06/21/22

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

ICE MACHINE WAS OBSERVED TO HAVE MOLD, CLEAN ICE MACHINE TO BE FREE OF MOLD.

Comply By: 06/21/22

Surface and Equipment Sanitizers

Acid: = 0 PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: Yes

Acid: = 900 PPM at Degrees Fahrenheit
Location: DISPENSER BY DISH MACHINE
Violation Issued: No

Food and Beverage Establishment Inspection Report

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: AMERICAN CHEESE LOCATED IN WIC
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: LIQUID EGGS LOCATED IN WIC
Violation Issued: No

Process/Item: Hot Holding
Temperature: 197 Degrees Fahrenheit - Location: CHICKEN PATTIE LOCATED IN HOT HOLD
Violation Issued: No

Process/Item: Hot Holding
Temperature: 174 Degrees Fahrenheit - Location: CHICKEN PATTIE LOCATED IN STEAM TABLE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 156 Degrees Fahrenheit - Location: STEAMED PEAS LOCATED IN STEAM TABLE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 143 Degrees Fahrenheit - Location: POTATOES LOCATED IN STEAM TABLE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 152 Degrees Fahrenheit - Location: GRAVY LOCATED IN STEAM TABLE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	1

DISCUSSION:

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.

Type: Full
Date: *06/21/22*
Time: 11:00:00
Report: 1017221104
Good Samaritan Society - Betha

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1017221104 of 06/21/22.

Certified Food Protection Manager: TINA GANGSTAD

Certification Number: FM 32571 Expires: 01/24/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
INSPECTOR ID # 1017

651-201-4500
health.foodlodging@state.mn.us

Report #: 1017221104

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	1	**Date**	06/21/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:00:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
Good Samaritan Society - Betha	1953 7th Street South	Brainerd, MN	56401	2188291407

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0039375		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 06/22/22

Inspector (Signature)