

Protecting, Maintaining and Improving the Health of All Minnesotans

March 17, 2023

Licensee Good Samaritan Society-Luverne 201 Oak Drive Luverne, MN 56156

RE: Project Number(s) SL20465015

Dear Licensee:

On February 22, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 21, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

centre pure

Casey DeVries, Supervisor State Evaluation Team Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 3879 St. Paul, MN 55101-3879 Telephone: 651-201-5917 Fax: 651-281-9796

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 23, 2023

Licensee Good Samaritan Society-Luverne 201 Oak Drive Luverne, MN 56156

RE: Project Number(s) SL20465015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 21, 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.

LICENSING ORDERS

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.

Good Samaritan Society-Luverne January 23, 2023 Page 2

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 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

The total amount you are assessed is \$3,000.00. 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 <u>email</u> general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Good Samaritan Society-Luverne January 23, 2023 Page 3

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. <u>Please note that you</u> <u>may request a reconsideration **or** a hearing, but not both</u>.

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,

John Jock

Jodi Johnson, Supervisor Health Regulation Division State Evaluation Team 85 East Seventh Place, Suite 220 P.O. Box 3879 St. Paul, MN 55101-3879 Email: jodi.johnson@state.mn.us Telephone: 507-344-2730 Fax: 651-215-9697

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		20465	B. WING		12/21/2022	
	PROVIDER OR SUPPLIER	LUVERNE 201 OAK		1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLE	
0 000	Initial Comments		0 000			
	CORRECTION OR In accordance with 144G.08 to 144G.9 issued pursuant to Determination of wh requires compliance provided at the Stat When Minnesota S failure to comply wi considered lack of of INITIAL COMMENT SL20465015-0 On December 19, 2 2022, the Minnesot conducted a survey the following correct time of the survey, the whom received serred Assisted Living licer An immediate correct December 20, 2022 2310. On December 21, 2 immediacy of correct	PROVIDER LICENSING DER(S) Minnesota Statutes, section 5, these correction orders are a survey. The ther violations are corrected e with all requirements tute number indicated below. tatute contains several items, th any of the items will be compliance. TS: 2022, through December 21, a Department of Health of the above provider, and tion orders are issued. At the there were 24 residents, 22 of vices under the provider's nse. ection order was identified on 2, issued for tag identification 2022, at 9:01 a.m. the ction order 2310 was non-compliance remained at		Minnesota Department of Health documenting the State Licensing Correction Orders using federal Tag numbers have been assigned Minnesota State Statutes for Assi- Living License Providers. The as- tag number appears in the far left entitled "ID Prefix Tag." The state number and the corresponding to state Statute out of compliance is the "Summary Statement of Defi column. This column also include findings which are in violation of requirement after the statement, Minnesota requirement is not me evidenced by." Following the sur- findings is the Time Period for Co PLEASE DISREGARD THE HEA THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN O CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECT VIOLATIONS OF MINNESOTA S STATUTES. The letter in the left column is us tracking purposes and reflects th and level issued pursuant to 144 subd. 1, 2, and 3.	software. ed to sisted ssigned ft column e Statute ext of the s listed in ciencies" es the the state "This et as veyors' orrection. ADING OF H F TO Y. THIS TO ION FOR STATE eed for he scope	
0 480 SS=F	144G.41 Subd 1 (1) requirements		0 480			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		20465	B. WING		12/	21/2022
AME OF F	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	•	
OOD S	AMARITAN SOCIETY	-LUVERNE 201 OAK	DRIVE E, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 480	Continued From pa	age 1	0 480			
	(13) offer to provide following services t	e or make available at least the o residents:)			
	available seven day recommended diet States Department	tritious meals daily with snacks ys per week, according to the ary allowances in the United of Agriculture (USDA) g seasonal fresh fruit and 'he following apply:	•			
		repared and served according ood Code, Minnesota Rules,				
	by: Based on observat review, the licensee Minnesota Food Co	ent is not met as evidenced ion, interview, and record e failed to adhere to the ode, Minnesota Rules, chapter e potential to affect all 24 illity.				
	violation that did no safety but had the p resident's health or cause serious injur was issued at a wid problems are perva- failure that has affe	ed in a level two violation (a ot harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic ected or has potential to affect II of the residents). The				
	included in the "Foo	additional documentation od and Beverage ection Reports," dated				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		20465	B. WING		CORRECTION ON SHOULD BE HE APPROPRIATE	21/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
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	December 19, 2022	-				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
0 680 SS=F	144G.42 Subd. 10 emergency prepare	Disaster planning and edness	0 680			
	requirements: (1) have a written e contains a plan for elements of shelter temporary relocatio assignments in the emergency; (2) post an emerge (3) provide building all residents; (4) post emergency and (5) have a written p missing tenant resid (b) The facility mus disaster training to orientation and ann make emergency a available to all resid received emergency allowed to work onl working on site. (c) The facility mus requirements adoption	t provide emergency and all staff during the initial staff ually thereafter and must and disaster training annually dents. Staff who have not and disaster training are y and disaster training are y when trained staff are also t meet any additional ted in rule.				
	by: Based on interview	ent is not met as evidenced and record review, the onduct two full scale drills in				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		20465	B. WING		12/	21/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	-LUVERNE 201 OAK	DRIVE E, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
0 680	Continued From pa	ige 3	0 680		,	
	the last year. This h residents.	ad the potential to affect all				
	violation that did no safety but had the p resident's health or widespread scope or represent a syste	ed in a level two violation (a ot harm a resident's health or potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings includ	e:				
	contained no evide	ergency Preparedness Plan nce the licensee had scale drills annually.				
	a.m. licensed assis stated she was in c preparedness prog	2022, at approximately 11:30 ted living director (LALD)-A harge of the emergency ram. The facility had op discussion but had not ale drill.				
	No additional inform	nation was provided.				
	TIME PERIOD FOI (21) days	R CORRECTION: Twenty-one				
0 970 SS=B	144.50 Subd. 5 Wa	ivers of liability prohibited	0 970			
	liability for the healt property of a reside include any provision should know to be unenforceable under	not include a waiver of facility th and safety or personal ent. The contract must not on that the facility knows or deceptive, unlawful, or er state or federal law, nor on that requires or implies a				

Minnesota Department of Health STATE FORM

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Bunnante Lianetment et Lianith		R4 was admitted to 1, 2021.	the ALF licensure on August				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		20465	B. WING		12/21/2022	
AME OF F	ROVIDER OR SUPPLIER	STREET A 201 OAK	DDRESS, CITY, ST	TATE, ZIP CODE		
OOD S/	AMARITAN SOCIETY	-I UVERNE	E, MN 56156			
X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE	
0 970	Continued From pa	ige 5	0 970			
	R4's service plan dated June 3, 2019, included this statement "HOLD HARMLESS The resident agrees to hold the agency harmless for any injury or damage which occurs during or after receiving services from the provider, unless such injury or damage is solely and directly caused by the provider."					
	R6 R6 was admitted to 1, 2021.	the ALF licensure on August				
	this statement "HO The resident agree for any injury or dar after receiving serv	s to hold the agency harmless mage which occurs during or ices from the provider, unless age is solely and directly				
	assisted living direct harmless statement removed in a newe signed service agree record contained th	2022, at 8:19 a.m. licensed ctor (LALD)-A stated the hold t in the service plan had been r version; however, the curren eements in R3, R4, and R6's he older version of the service harmless statement and should l.	t			
	No further informat	ion was provided.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
01370 SS=E	144G.61 Subd. 2 (a unlicensed personr	a) Training and evaluation of n	01370			
	(a) Training and co	mpetency evaluations for all				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		20465	B. WING		12/	21/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	-LUVERNE 201 OAK	DRIVE E, MN 56156			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIATE	COMPLET DATE
01370	Continued From pa	ige 6	01370			
	 (1) documentation in provided; (2) reports of change to the supervisor defection of pathogens; (4) maintenance of environment; (5) appropriate and hygiene and groom (i) hair care and bard (ii) care of teeth, guidevices; (iii) care of teeth, guidevices; (iii) care and use of (iv) dressing and as (6) training on the properties of the them; (8) medication, exereminders; (9) basic nutrition, r and assistance with (10) preparation of licensed health proficensed health proficensed health proficensed health proficenses of the resident and the cultural background (12) awareness of a (13) understanding between staff and r family; (14) procedures to emergency situatio (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultural background (15) awareness of a technology equipment and the cultura	safe techniques in personal ing, including: thing; ums, and oral prosthetic thearing aids; and ssisting with toileting; prevention of falls; nce techniques and how to ercise, and treatment meal preparation, food safety, n eating; modified diets as ordered by a fessional; n skills that include preserving sident and showing respect for e resident's preferences, d, and family; confidentiality and privacy; appropriate boundaries residents and the resident's use in handling various				

STATE FORM

6KHJ11

If continuation sheet 7 of 25

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00.405	B. WING			
		20465			12/	21/2022
		201 044	DDRESS, CITY, S ⁻ C DRIVE	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		IE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
01370	Continued From pa	ige 7	01370			
	review, the licensee unlicensed personr	ion, interview, and record e failed to ensure two of two hel (ULP-C and ULP-D) and competency evaluations ng topics.				
	violation that did no safety but had the p resident's health or cause serious injury was issued at a pat limited number of ro than a limited numb	ed in a level two violation (a tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death) and ttern scope (when more than a esidents are affected, more per of staff are involved, or the red repeatedly; but is not ve).				
	The findings include	e:				
	direct care and serv residents under the license. ULP-C beg	n March 7, 2011, to provide vices to the licensee's comprehensive home care an providing direct care and assisted living licensure on				
	observed administe	2022, at 7:00 a.m. ULP-C was ering medications and at 11:00 oserved checking blood				
	observed administe	2022, at 11:16 a.m. ULP-C was ering medication to R2, and at ninistered medication to R4.				
	completed training following:	record lacked evidence of and/or competency for the s in the resident's condition to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		20465	B. WING		12/2	21/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	-LUVERNE 201 OAK LUVERNE	DRIVE 5, MN 56156			
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE	(X5) COMPLET DATE
TAG	REGULATORT OR E		TAG	DEFICIENCY		BATE
01370	Continued From pa	ige 8	01370			
	 appropriate and so hygiene and groom hair care and care of teeth, devices; and dressing and medication, exerciand understanding appropriate 					
	ULP-D was hired of direct care and serv residents under the license. ULP-D beg	n January 22, 2020, to provide vices to the licensee's comprehensive home care gan providing direct care and assisted living licensure on				
	completed training following: - documentation re- provided; - reports of change the supervisor desig - standby assistance perform them; - medication, exerc - understanding app staff and residents - procedures to use emergency situation - awareness of corr equipment and ass	nmonly used health technology uasive devices.				
nanata Di		2022, at 11:10 a.m. licensed ctor (LALD)-A stated she was				

If continuation sheet 9 of 25

TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		20465	B. WING		12/	21/2022
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	LUVERNE 201 OAK	DRIVE E, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
01370	Continued From pa	age 9	01370			
	and she was worki	n was missing some things ng on correcting it. All required ave been provided to the				
	Employees, Minnes dated December 12 competency for UL 1. Refer to and follo global Society polic 2. In addition to So requirements, train evaluations for all u include: A. Documentation to provided. B. Reports of chan to the supervisor de C. Basic infection of pathogens. D. Maintenance of E. Appropriate and hygiene and groom i. Hair care and bad	ow any and all applicable cies and/or procedures. ciety staff member training ing and competency unlicensed personnel must requirements for all services ges in the resident's condition esignated by the facility. control, including blood-borne a clean and safe environment. safe techniques in personal ning, including:				
	devices iii. Care and use of iv. Dressing and as F. Training on the p G. Standby assista perform them. H. Medication, exe reminders. I. Basic nutrition, m and assistance with	hearing aids ssisting with toileting prevention of falls. nce techniques and how to rcise, and treatment leal preparation, food safety, n eating.				
	licensed health pro K. Communication	odified diets as ordered by a fessional. skills that include preserving sident and showing respect for				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		20465	B. WING		12/2	21/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	LUVERNE 201 OAK	CDRIVE IE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01370	Continued From pa	age 10	01370			
	cultural background L. Awareness of co M. Understanding a between staff and r family. N. Procedures to u emergency situatio O. Awareness of co technology equipm No further informat	onfidentiality and privacy. appropriate boundaries residents and the resident's se in handling various ns; and ommonly used health ent and assuasive devices.				
01380 SS=E	unlicensed person (b) In addition to pa competency evalua providing assisted I (1) observing, repo resident status; (2) basic knowledg changes in body fu observed changes appropriate person (3) reading and rec and respirations of (4) recognizing phy and developmental (5) safe transfer tea (6) range of motion (7) administering m required.	aragraph (a), training and ation for unlicensed personnel living services must include: rting, and documenting e of body functioning and nctioning, injuries, or other that must be reported to nel; cording temperature, pulse,	01380			

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
				· · · · · · · · · · · · · · · · · · ·		
		20465	B. WING		12/	21/2022
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	-LUVERNE 201 OAK	IE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
01380	Continued From pa	age 11	01380			
	review, the licensee unlicensed personr	ion, interview, and record e failed to ensure two of two nel (ULP-C and ULP-D) and competency evaluations ng topics.				
	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 includ	e:				
	direct care and services of the service of the serv	n March 7, 2011, to provide vices to the licensee's comprehensive home care gan providing direct care and assisted living licensure on				
	observed administe	2022, at 7:00 a.m. ULP-C was ering medications, and at 11:00 oserved checking blood				
	observed administe	2022, at 11:16 a.m. ULP-C was ering medication to R2, and at ninistered medication to R4.				
	completed training following:	record lacked evidence of and/or competency for the ng, and documenting resident				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		20465	B. WING		12/	12/21/2022	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	-LUVERNE 201 OAK	DRIVE E, MN 56156				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
01380	status; - basic knowledge of changes in body fur observed changes appropriate person - recognizing physic developmental nee - safe transfer tech - range of motioning ULP-D ULP-D was hired of direct care and services residents under the license. ULP-D beg services under the August 1, 2021. ULP-D's employee completed training following: - observing, reporting status; - basic knowledge of changes in body fur observed changes appropriate person - recognizing physic developmental nee - safe transfer tech - range of motioning On December 21, 2 assisted living direct aware the educatio and she was working	of body functioning and nctioning, injuries, or other that must be reported to nel; cal, emotional, cognitive, and ds of the resident; niques and ambulation; and g and positioning. n January 22, 2020, to provide vices to the licensee's e comprehensive home care gan providing direct care and assisted living licensure on record lacked evidence of and/or competency for the ng, and documenting resident of body functioning and nctioning, injuries, or other that must be reported to nel; cal, emotional, cognitive, and ds of the resident; niques and ambulation; and		DEFICIENC	T)		

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		20465	B. WING		12/	21/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	-LUVERNE 201 OAK LUVERN	DRIVE E, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01380	Employees, Minnes dated December 13 competency for UL A. Observing, repor- resident status. B. Basic knowledge changes in body fu observed changes appropriate person C. Reading and rec and respirations of D. Recognizing phy and developmental E. Safe transfer teo F. Range of motion G. Administering m required. No further informat	sota- Assisted Living policy 3, 2022, identified training and P's was to include: rting, and documenting e of body functioning and nctioning, injuries, or other that must be reported to nel. cording temperature, pulse, the resident. vsical, emotional, cognitive, needs of the resident. chniques and ambulation. ing and positioning. edications or treatments as	01380			
01620 SS=E	assessments, and (c) Resident reasse be conducted no m after initiation of se reassessment and as needed based o resident and canno from the last date o (d) For residents or services specified i 9, clauses (1) to (5) individualized initial and preferences. T	monitoring essment and monitoring must ore than 14 calendar days rvices. Ongoing resident monitoring must be conducted n changes in the needs of the t exceed 90 calendar days				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED	
		20465	B. WING		12/	21/2022
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY	LUVERNE 201 OAF	CDRIVE IE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
01620	Continued From pa	ge 14	01620			
	services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a comprehensive assessment was completed every 90 days for two of three residents (R4, R6) receiving assisted living services.					
	violation that did no safety but had the p resident's health or cause serious injur was issued at a par limited number of ro than a limited numb	ed in a level two violation (a at harm a resident's health or botential to have harmed a safety, but was not likely to y, impairment, or death), and ttern scope (when more than a esidents are affected, more ber of staff are involved, or the red repeatedly; but is not ve).				
	The findings include	e:				
		nder the comprehensive home le 25, 2020, and the assisted gust 1, 2021.	;			
	R4's service plan d identified R4 receiv	ated October 25, 2022,				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		20465	B. WING		12/21/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	-LUVERNE 201 OAK	DRIVE E, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01620	Continued From pa	ige 15	01620			
	medication adminis	stration, bathing, and meals.				
	23, 2021. The next in her record was d days). - a Uniform Assess 2022. The next Uni	ed the following; ment Review dated December Uniform Assessment Review lated June 16, 2022 (175 ment Review dated July 15, form Assessment Review in ed October 20, 2022 (97				
		nder the comprehensive home rch 29, 2021, and the assisted gust 1, 2021.				
	identified R6 receiv	ated March 29, 2021, ed services including stration, bathing, and meals.				
	1, 2022, and a Unif June 6, 2022 (97 d	f Care Evaluation dated March orm Assessment review dated ays) Assessment Review was dated				
	2022, at 11:30 a.m. stated ongoing com	e conference on December 19 registered nurse (RN)-B nprehensive assessments least every 90 days.	,			
	assisted living direct comprehensive ass at least every 90 da	2022, at 8:19 a.m. licensed ctor (LALD)-A stated a sessment should be completed ays. She was made aware they eleted timely and she was t.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		20465	B. WING	B. WING		12/21/2022	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	201 OAP	K DRIVE NE, MN 56156				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
01620	Continued From pa	age 16	01620				
	Living dated Octob initial Level of Care Assessment and L (PCC/EMR) will be nurse (RN) for eac admission, and up condition. Periodic be completed by a	sident Assessment-Assisted er 4, 2022, identified "The e Evaluation-AL or Nursing evel of Care Evaluation - AL completed by a registered h resident prior to or upon on significant change in and annual evaluations may licensed nurse where allowed ving (AL) and board of nursing					
	No further informat	tion was provided.					
	TIME PERIOD FO (21) days	R CORRECTION: Twenty-one					
01700 SS=F	144G.71 Subd. 2 P management servi	Provision of medication ces	01700				
	management servi providing medication a registered nurse, or authorized preso conduct an assess medication manage provided and how to This assessment in with the resident. The an identification and resident is known to identification mustor medications, side effective allergic or adverse address these issues (b) The assessment	ent who requests medication ces, the facility shall, prior to on management services, have licensed health professional, criber under section 151.37 ment to determine what ement services will be the services will be provided. nust be conducted face-to-face the assessment must include d review of all medications the o be taking. The review and include indications for effects, contraindications, reactions, and actions to les. nt must identify interventions ment of medications to preven	e •				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		20465	B. WING		12/	21/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	-LUVERNE 201 OAK	DRIVE E, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
01700	Continued From pa	age 17	01700			
	who may have according provide instructions designated represent manage the residered diversion of medical section, "diversion of theft, or illegal or immedications. This MN Requiremed by: Based on interviewed licensee failed to have for three of three resident or other the resident or other the medications and resident and legal of on interventions to reventions to the resident or the resident and legal of on interventions to the resident and legal of on interventions to the reventions to the	ation by the resident or others ess to the medications and s to the resident and legal or entatives on interventions to nt's medications and prevent ations. For purposes of this of medication" means misuse, nproper disposition of ent is not met as evidenced and document review, the ave a medication assessment esidents (R3, R4, and R6) that ons needed in management of vent diversion of medication by ers who may have access to d provide instructions to the or designated representatives manage the resident's vent diversion of medications.				
	violation that did no safety but had the p resident's health or widespread scope or represent a syste	ed in a level two violation (a ot harm a resident's health or potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings includ	e:				
	interventions needed medications to prevente the resident or othe	nedication assessment lacked ed in management of vent diversion of medication by ers who may have access to d provide instructions to the	,			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		20465	B. WING		12/	21/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		K DRIVE NE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
01700	Continued From pa	age 18	01700			
	on interventions to medications and pr medications.	manage the resident's revent diversion of				
	R3 R3 was admitted up on September 19, 2	nder the assisted living license 2022.	e			
		ated October 1, 2022, red services including stration.				
	identified the reside administration serv identify risk for dive interventions to ma	sment dated October 6, 2022 ent received medication ices. The assessment failed t ersion of medications and nage the residents's ent diversion of medications.				
		nder the comprehensive homore ne 25, 2020, and the assisted igust 1, 2021.				
		ated October 25, 2022, red medication administration.				
	2022, identified the administration serv identify risk for dive interventions to ma	sment dated October 20, resident received medication ices. The assessment failed t ersion of medications and nage the residents's ent diversion of medications.				
		nder the comprehensive homory rch 29, 2021, and the assisted igust 1, 2021.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		20465	B. WING			
IAME OF F	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST		12/	21/2022
	AMARITAN SOCIETY	-LUVERNE 201 OA	K DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01700	Continued From pa	age 19	01700			
	R6's service plan dated March 29, 2021, identified R6 received medication administration.		1.			
	2022, identified R6 administration serv identify risk for dive interventions to ma	ssment dated September 26, received medication rices. The assessment failed ersion of medications and unage the residents's ent diversion of medications.	to			
	nurse (RN)-B state tool used did not id	2022, at 1:52 p.m. registered d the medication assessmen entify the risk for diversion or event diversion of medications	t			
	assisted living direct	2022, at 11:27 a.m. licensed ctor (LALD)-A stated if the it in the resident record, it had d.	E			
	No further informat	ion was provided.				
	TIME PERIOD FO	R CORRECTION: Seven (7)				
02310 SS=I	144G.91 Subd. 4 (a services	a) Appropriate care and	02310			
	living services that resident's needs ar	e the right to care and assiste are appropriate based on the nd according to an up-to-date of to accepted health care	•			
	by: Based on observat	ent is not met as evidenced ion, interview, and record e failed to provide care and				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	20465	B. WING		12/	21/2022
IDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RITAN SOCIETY					
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
vices according edical, or nursing sidents (R4, R6) v immediate order 22, at approxima is practice result lation that harme t including seriou a violation that har- ious injury, impa- ued at a widespr e pervasive or rep s affected or has rtion or all of the e findings include began receiving ing Facility (ALF) December 20, 2 served a consum e right side of R4 al shape attached ard, it was attached ard, it was attached bed frame on th 's Resident Evalu-	to acceptable health care, standards for two of two with side rails. This resulted in r issued on December 20, itely 9:15 a.m. ed in a level three violation (a ed a resident's health or safety is injury, impairment, or death, as the potential to lead to irrment, or death) and was read scope (when problems present a systemic failure that potential to affect a large residents). e: g services under the Assisted) license on August 1, 2021. 2022, at 8:50 a.m. the surveyon rer grab bar type side rail on 's bed. The grab bar was an d to a tube that went down to a need to the board and the board ne mattress and box spring. attached that was secured to ne left side of the bed. uation for Assist Grab Bars 2, identified R4 had an assist	r	DEFICIENC	27)	
	DEFICIENCIES CORRECTION ARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ritinued From pa cvices according edical, or nursing sidents (R4, R6) immediate order 22, at approximal is practice result lation that harmed t including seriou a violation that h rious injury, impa ued at a widespr e pervasive or rep s affected or has rition or all of the e findings include began receiving ing Facility (ALF began receiving ing Facility (ALF began receiving ing Facility (ALF began statache ard, it was attache ard, it was attache s slid between th e bed frame on th 's Resident Eval ted April 14, 2022 ab bar that she u	EDEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20465 VIDER OR SUPPLIER STREET AL 201 OAK LUVERNE ARITAN SOCIETY-LUVERNE 201 OAK LUVERN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 20 rvices according to acceptable health care, edical, or nursing standards for two of two sidents (R4, R6) with side rails. This resulted in immediate order issued on December 20, 22, at approximately 9:15 a.m. Is practice resulted in a level three violation (a lation that harmed a resident's health or safety tincluding serious injury, impairment, or death, a violation that has the potential to lead to rious injury, impairment, or death) and was ued at a widespread scope (when problems e pervasive or represent a systemic failure that s affected or has potential to affect a large rtion or all of the residents). e findings include: began receiving services under the Assisted ing Facility (ALF) license on August 1, 2021. a December 20, 2022, at 8:50 a.m. the surveyo served a consumer grab bar type side rail on e right side of R4's bed. The grab bar was an al shape attached to a tube that went down to a	EDEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING: 20465 B. WING MIDER OR SUPPLIER STREET ADDRESS, CITY, ST 201 OAK DRIVE LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Intinued From page 20 02310 rvices according to acceptable health care, edical, or nursing standards for two of two isidents (R4, R6) with side rails. This resulted in immediate order issued on December 20, 22, at approximately 9:15 a.m. 02310 is practice resulted in a level three violation (a lation that has the potential to lead to rious injury, impairment, or death, a violation that has the potential to lead to rious injury, impairment, or death, and was ued at a widespread scope (when problems e pervasive or represent a systemic failure that s affected or has potential to affect a large rtion or all of the residents). Ib began receiving services under the Assisted ing Facility (ALF) license on August 1, 2021. 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WING ARITAN SOCIETY-LUVERNE 201 OAK DRIVE LUVERNE, IM 56156 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREVIDERS, CITY, STATE, ZIP CODE 201 OAK DRIVE LUVERNE, IM 56156 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREVIDERS, CITY, STATE, ZIP CODE ntinued From page 20 02310 vices according to acceptable health care, dical, or nursing standards for two of two idents order issued on December 20, 22, at approximately 9:15 a.m. 02310 is practice resulted in a level three violation (a lation that has the potential to lead to rious injury, impairment, or death, a violation that has the potential to lead to rious injury, impairment, or death, a violation that has the potential to affect a large trion or all of the residents). e findings include: began receiving services under the Assisted ing Facility (ALF) license on August 1, 2021. 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	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		20465	B. WING		12/	21/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	-LUVERNE 201 OAK	DRIVE E, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
02310	Continued From pa	age 21	02310			
	2022, through Dece unlicensed personr	ion Record for December 1, ember 20, 2022, identified the nel (ULP), had completed bed ecks every day at bedtime.				
	R6 R6 began receiving license on August 1	services under the ALF 1, 2021.				
	observed a consum of R6's bed. The signature running through the two bars at the bott down and slid betw spring. There was a	2022, at 8:52 a.m. the surveyo her half side rail on the left side de rail had two horizontal bars e center of the rail. The rail had tom of the rail that extended reen the mattress and box a strap attached that was frame on the right side of the	e			
	dated April 14, 202 grab bar that she u to identify the brand grab bar was instal instructions or that	uation for Assist Grab Bars 2, identified R6 had an assist sed to aid in mobility. It failed d/type of side rail used, if the led per manufacturer the Consumer Product Safety C) had been checked for any				
	2022, through Dece registered nurse (R rail safety checks o	ion Record for December 1, ember 20, 2022, identified the RN), had completed bed assist on December 1, 2022, , and December 15, 2022.				
	the facility did not h for any of the consi	2022, at 8:55 a.m. RN-B stated have manufacturer instructions umer side rails/grab bars to allation, and she had not				

STATE FORM

6KHJ11

If continuation sheet 22 of 25

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			B. WING			
		20465			12/	21/2022
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	-LUVERNE 201 OAK	DRIVE E, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
02310	Continued From pa	ige 22	02310			
	assisted living direct did not have manuf consumer side rails checked for recalls indicated the familie or grab bars and we sure they were insta The licensee's Bed Living policy dated Consumer Product that 155 fatalities he adult portable side (83% of the deaths and older and 10% settings). Not all re- rail/side rail entrapr rails pose a risk. Be be used to promote with bed mobility ar reposition, enter an rail/side rail that pre- the bed independen potential for serious related to a fall from rails/side rails wher over, around, betwee from a bed without completion and door resident assessme rail/side rail risks ar of bed rail/side rail is in us be designed to wor including the side rail	2022, at 9:15 a.m. licensed ctor (LALD)-A stated the facility facturer instructions for the s/grab bars and she had not on them. The facility's policy es were to install the bed rails ere responsible for making alled correctly. Rail/Side rail Use- Assisted October 3, 2022, The Safety Commission identified ave occurred due to the use of rails between 2003 and 2012 occurred in people 60 years of the deaths occurred in AL esidents are at risk for bed ment, and not all bed rails/side ed rails/side rails should only a resident's independence and enable the resident to safely ad/or exit the bed. Any bed events a resident from exiting ntly is a restraint." "The is injury is more likely to be in a bed with raised bed in the resident attempts to climate en or through the rails than bed rails/side rails in use. The cumentation of specific ints, education regarding bed and benefits and an evaluation safety is required when a bed e. The bed rail/side rail must k with the bed "system" ail, bed frame and mattress. obly" bed rail/side rail will not				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. DUILDING			
		20465	B. WING		12/	21/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	201 OAK 201 OAK LUVERNE	DRIVE E, MN 56156			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
02310	Continued From pa	age 23	02310			
	children will not be used.					
	C. A bed rail/side	rail is not allowed unless				
	manufacturer's rec	ommendations for use can be				
		mined appropriate. The AL				
	•	nsible to carry out the following	9			
		f whether the bed rail/side rail				
		or installed by a third-party				
		will assess the reason the bec	k			
		e used, The registered nurse				
		nitor the resident for the				
		sk conditions that pose a				
		rapment. The nurse will				
		/side rail will be installed and				
		rdance to the manufacturer's				
		8. The registered nurse will				
		ve assessments and actions or	ו			
		ation for Assist Grab Bars-AL				
		lectronic medical record)				
	according to the fol A. Prior to bed rai					
		ant change In condition, and				
	C. Annually"	-				
		e will conduct an annual audit il/side ails in used and to				
		ave been recalled."				
	The Minnesota De	partment of Health (MDH)				
	website, Assisted L					
		Questions (FAQs) indicated,				
		vidual is an appropriate				
		d rail, the licensee must assess	s			
		nitive and physical status as				
		bed rail to determine the				
	intended purpose f	or the bed rail and whether				
		gh risk for entrapment or falls.				
	This may include a	ssessment of the individual's				
		s, pain, uncontrolled body				
		y to transfer in and out of bed				
		The licensee must also				
		he bed rail has the effect of				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING			
		20465	B. WING		12/2	21/2022
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	-LUVERNE 201 OAK	K DRIVE IE, MN 56156			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLET DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY		DATE
02310	Continued From pa	age 24	02310			
	"Documentation ab includes, but is not - Purpose and inter - Condition and des enough for a reside the bed rail; - The resident's be - Risk vs. benefits de each resident's risk - The resident's risk - The resident's pre - Installation and us guidelines; - Physical inspection areas of entrapment installation; and - Any necessary inf	ntion of the bed rail; scription (i.e., an area large ent to become entrapped) of d rail use/need assessment; discussion (individualized to (s); eferences; se according to manufacturer's on of bed rail and mattress for nt, stability, and correct formation related to tigate safety risk or negotiated	5			
		R CORRECTION: IMMEDIATE	Ξ			
	observation and do	noved as confirmed by onsite ocument review on December .m.; however, non-compliance widespread (I).				
	TIME PERIOD FOI days	R CORRECTION: Two (2)				



 Type:
 Full

 Date:
 12/19/22

 Time:
 12:00:00

 Report:
 1033221202

Food and Beverage Establishment Inspection Report

Page 1

Location:

Good Samaritan Society-Luverne 201 Oak Drive Luverne, MN56156 Rock County, 67 Establishment Info: ID #: 0038862 Risk: Announced Inspection: No

License Categories:

Expires on: / /

- Operator:

Phone #: 5072831996 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.

3-300A Protection from Contamination: limit hand contact, tasting

3-301.11A ** Priority 1 **

MN Rule 4626.0225A Discontinue bare hand contact with ready-to-eat foods. Use deli tissue, spatulas, tongs, single-use gloves or other dispensing equipment.

Employee serving food was observed handling ready to eat hot dogs with their bare hands. *Comply By: 12/19/22*

6-200 Physical Facility Design and Construction 6-202.15A

MN Rule 4626.1395A Seal holes, gaps, and other openings along floors, walls and ceilings to the outside of the building and provide self-closing, tight-fitting doors and windows for all outside openings.

Exterior door has visible light shining through at the bottom. *Comply By: 12/26/22*

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit Location: Dish Machine Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding Temperature: 36 Degrees Fahrenheit - Location: Cooler Violation Issued: No

Type:FullFood and Beverage EstablishmentDate:12/19/22Inspection ReportTime:12:00:00Inspection ReportReport:1033221202Good Sarritan Society-Luverne	Page 2
Process/Item: Cold Holding Temperature: 0> Degrees Fahrenheit - Location: Freezer Violation Issued: No	
Process/Item: Hot Holding Temperature: 147 Degrees Fahrenheit - Location: Enchiladas-Steam Well Violation Issued: No	
Process/Item: Hot Holding Temperature: 170 Degrees Fahrenheit - Location: Hot Dogs-Steam Well Violation Issued: No	
Total Orders In This ReportPriority 1Priority 2Priority 3101	
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, rem alterations. I acknowledge receipt of the inspection report number 1033221202 of 12/19/22	-
Certified Food Protection ManagerPamela K Baker	
Certification Number: <u>FM97302</u> Expires: <u>02/05/25</u>	
Inspection report reviewed with person in charge and emailed.	
Signed: Signed:	

Pamela K Baker

Isaiah Armendariz Environmental Health Specialist Mankato District Office 507-344-2743 isaiah.armendariz@state.mn.us