Electronically Delivered

May 7, 2026

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

RE: Project Number(s) SL20465016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 2, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH 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.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH 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 may be 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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted 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(s) 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20465	A. BUILDING: _____ B. WING _____	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-LUVERNE	201 OAK DRIVE LUVERNE, MN 56156

(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 *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are 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: SL20465016-0 On March 30, 2026, through April 2, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 25 residents; 24 receiving services under the Assisted Living Facility license. 2310: An immediate correction order was issued on April 1, 2026, at a level 3/Widespread. The licensee took immediate action; however, the scope and level remain at l.	0 000		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	0 660		

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0 660	Continued From page 1 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB screening upon hire for two of two employees (unlicensed personnel (ULP)-D, ULP-E). 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: ULP-D ULP-D was hired on March 4, 2024, and provided direct care services to the residents residing within the facility.	0 660		

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0 660	Continued From page 2 On March 30, 2026, at 10:54 a.m. the surveyor observed ULP-D administering medications to the residents. ULP-D's employee record included a tuberculosis blood test completed on March 5, 2024. ULP-D's record lacked evidence of a Baseline TB (tuberculosis) Screening Tool for Health Care Workers. ULP-E ULP-E was hired on November 15, 2025, and provided direct care services to the facility's residents. On March 31, 2026, at 7:28 a.m., the surveyor observed ULP-E administering medications to the residents. ULP-E's employee record included a tuberculosis blood test completed on November 18, 2025. Although ULP-E was hired on November 15, 2025, and the blood test was completed November 18, 2025, ULP-E's Baseline TB Screening Tool for Health Care Workers was dated September 18, 2025, two months prior to hire and blood test. On April 1, 2026, at 3:01 p.m., licensed assisted living director (LALD)-B stated ULP-D did not have a TB Screening Tool in her employee record. Assisted living director in residency (ALDIR)-A stated ULP-E came from another state and interviewed, returned to the other state and came back two months later to work for the licensee. ULP-E should have had the TB Screening Tool completed at the time of hire and should have correlated with the TB blood test.	0 660		

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0 660	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
01320 SS=D	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of two unlicensed personnel (ULP-E) to include all required content. 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	01320		

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01320	Continued From page 4 cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired on November 15, 2025, and provided direct care services to the facility's residents. On March 31, 2026, at 7:28 a.m., the surveyor observed ULP-E administering medications to the residents. ULP-E's employee record lacked evidence of training for the following topics: -documentation requirements for all services provided -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -standby assistance techniques and how to perform them; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; and -awareness of commonly used health technology	01320		

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01320	Continued From page 5 equipment and assistive devices. On April 2, 2026, at 12:26 a.m., licensed assisted living director (LALD)-B stated ULP-E did not complete all of her assigned training; therefore, if it is not listed on her transcript, it was not completed. The licensee's Required Training for All Employees, Minnesota- Assisted Living policy dated March 17, 2026, included: "In addition to Society staff member training requirements, training and competency evaluations for all unlicensed personnel must include: A. Documentation requirements for all services provided. B. Reports of changes in the resident's condition to the supervisor designated by the facility. D. Maintenance of a clean and safe environment. E. Appropriate and safe techniques in personal hygiene and grooming, including: i. Hair care and bathing ii. Care of teeth, gums, and oral prosthetic devices iii. Care and use of hearing aids iv. Dressing and assisting with toileting G. Standby assistance techniques and how to perform them. H. Medication, exercise, and treatment reminders. I. Basic nutrition, meal preparation, food safety, and assistance with eating. J. Preparation of modified diets as ordered by a licensed health professional. L. Awareness of confidentiality and privacy. M. Understanding appropriate boundaries between staff and residents and the resident's family; and O. Awareness of commonly used health	01320		

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01320	Continued From page 6 technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel (ULP-D, ULP-E) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01330		

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01330	Continued From page 7 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D ULP-D was hired on March 4, 2024, and provided direct care services to the residents residing within the facility. On March 30, 2026, at 10:54 a.m., the surveyor observed ULP-D administering medications to the residents. ULP-D's employee record lacked evidence of competency testing for the following topics: - safe transfer techniques and ambulation; and - range of motioning. ULP-E ULP-E was hired on November 15, 2025, and provided direct care services to the facility's residents. On March 31, 2026, at 7:28 a.m., the surveyor observed ULP-E administering medications to the residents. ULP-E's employee record lacked evidence of training for the following topics: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to	01330		

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01330	Continued From page 8 appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. On April 2, 2026, at 12:26 a.m., licensed assisted living director (LALD)-B stated ULP-E did not complete all of her assigned training; therefore, if it is not listed on her transcript, it was not completed. LALD-A stated ULP-D should have had competency testing for all transfer techniques, ambulation, and range of motion. The licensee's Required Training for All Employees, Minnesota- Assisted Living policy dated March 17, 2026, included: "Training and competency evaluation for unlicensed personnel providing assisted living services must include: A. Observing, reporting, and documenting resident status B. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. C. Reading and recording temperature, pulse, and respirations of the resident. D. Recognizing physical, emotional, cognitive, and developmental needs of the resident. E. Safe transfer techniques and ambulation. F. Range of motioning and positioning. G. Administering medications or treatments as required." No further information was provided.	01330		

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01330	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for two of two unlicensed	01440		

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01440	Continued From page 10 personnel (ULP)-D, ULP-E). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D ULP-D was hired on March 4, 2024, and provided direct care services to the residents residing within the facility. On March 30, 2026, at 10:54 a.m., the surveyor observed ULP-D administering medications to the residents. ULP-D's employee record lacked evidence a registered nurse completed a supervision of delegated tasks within 30 days of ULP-D performing delegated tasks. ULP-E ULP-E was hired on November 15, 2025, and provided direct care services to the facility's residents. On March 31, 2026, at 7:28 a.m., the surveyor observed ULP-E administering medications to the residents. ULP-E's employee record indicated clinical nurse supervisor (CNS)-C had observed ULP-E pass medications on March 5, 2026; however, ULP-E's	01440		

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01440	Continued From page 11 record lacked evidence a registered nurse completed a supervision of delegated tasks within 30 days of ULP-D performing delegated tasks. On April 2, 2026, at 8:45 a.m., licensed assisted living director (LALD)-B stated ULP-D's record did not include a 30 day supervision. At 9:50 a.m., LALD-B further stated ULP-E's 30 day supervision was not completed within 30 days of performing delegated tasks as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints,	01470		

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GOOD SAMARITAN SOCIETY-LUVERNE	201 OAK DRIVE LUVERNE, MN 56156

(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
01470	Continued From page 12 including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01470		

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01470	Continued From page 13 review, the licensee failed to ensure one of one unlicensed personnel (ULP-E) received orientation to include the required content. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on November 15, 2025, and provided direct care services to the facility's residents. On March 31, 2026, at 7:28 a.m., the surveyor observed ULP-E administering medications to the residents. ULP-E's employee record lacked evidence ULP-E had completed the following required orientation topics: - Overview of Assisted Living statutes - Reporting maltreatment of vulnerable adults or minors - Assisted Living Bill of Rights - Handing of resident complaints, reporting of complaints, where to report - Consumer advocacy services - Principles of person-centered planning/service delivery On April 2, 2026, at 12:26 a.m. licensed assisted living director (LALD)-B stated ULP-E did not complete all of her assigned training; therefore, if	01470		

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01470	Continued From page 14 it is not listed on her transcript, it was not completed. The licensee's Required Training for All Employees, Minnesota- Assisted Living policy dated March 17, 2026, included the orientation will contain the following topics: A. Overview of Chapter 144G. D. Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC). E. Assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. F. The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. G. Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints (OHFC) H. Consumer Advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	01500		

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01500	Continued From page 15 for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01500		

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01500	Continued From page 16 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-D). 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 is 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: ULP-D was hired on March 4, 2024, and provided direct care services to the residents residing within the facility.	01500		

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01500	Continued From page 17 On March 30, 2026, at 10:54 a.m., the surveyor observed ULP-D administering medications to the residents. ULP-D's employee record lacked evidence annual training of the following required topics had been completed: - Review of provider's policies and procedures; and - Principles of person-centered planning/service delivery On April 1, 2026, at 3:01 p.m., assisted living director in residency (ALDIR)-A stated the last review of provider policies had been completed on March 6, 2024, and had not been completed annually. ALDIR-A further stated annual person centered care training had been assigned to ULP-D, but it had not been completed. The licensee's Required Training for All Employees, Minnesota- Assisted Living policy dated March 17, 2026, indicated annual training included: - The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. - Review of the facilities policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 18 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must	01620		

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01620	Continued From page 19 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. (f) 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 observation, interview, and record review, the licensee failed to complete a comprehensive assessment after a change of condition for one of one resident (R2). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on August 30, 2013, and began receiving assisted living services on August 1, 2021. On March 31, 2026, at 7:48 a.m., the surveyor observed unlicensed personal (ULP)-E completing wound care and applying an orthotic boot to R2's right foot. R2's Progress Notes included the following:	01620		

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01620	Continued From page 20 - January 31, 2026, indicated R2 had been to the emergency room (ER) for foot discomfort and an open wound. - February 4, 2026, clinical nurse supervisor (CNS)-C faxed the medical provider for orders for the wound care. - February 6, 2026, orders were received from the medical provider for "Mepilex dressing (foam) changed every 3 days and PRN [as needed] to right foot wound." - February 11, 2026, CNS-C noted, "Talked with [R2] this morning regarding wound to right foot; still red and sore to the touch; does have a slight odor to it now; she will call clinic to setup an appt [appointment] with her doctor to be seen; may need wound consult also." - February 17, 2026, CNS-C documented "90 day assessment and review completed; resident remains at a level 3 for healthcare services; currently receiving 2x/week treatment and PRN to right foot wound; staff assist with med [medication] administration and bathing; set up for dressing and apply and remove TED [thrombo-embolic deterrent] hose daily. resident uses electric wheelchair for mobility. No changes made to service agreement; service plan updated." - February 27, 2026, "wound clinic referral placed for March 4th for wound to right foot." "resident seen yesterday for right foot wound infection; started on 2 antibiotics and now has referral to wound clinic". - March 4, 2026, R2 was seen by wound clinic and had new wound care orders. - March 11, 2026, R2 was seen by the wound clinic with no changes to orders. R2's emergency department report dated January 31, 2026, included the following: - R2 was at the (ER) with "complaints of ulcer to	01620		

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01620	Continued From page 21 R [right] foot. Patient notes she first saw it about 2 days ago, was a bit painful so has been taking Tylenol for the pain (last took it last night). Today she noticed swelling and redness to the area so came to get it checked out."; - R2's diagnoses included right foot ulceration and cellulitis (infection of the tissue) to the right foot; - wound description "2x2 cm [centimeter] circular wound to proximal shin with scant oozing of blood. <1 cm [less than 1 centimeter] circular ulcerative wound to right 5th head of metatarsal [outer foot] area with surrounding errythema [redness] and slight foul smell"; and - dressings were applied to the wound and R2 was discharged with orders for antibiotics. R2's physician orders dated February 6, 2026, included Mepilex border foam change every three days and as needed. R2's physician orders from a wound care provider dated March 11, 2026, indicated R2 had surgical debridement of the right foot wound. Staff were to change the dressing to the wound every other day with the following instructions: - clean with saline rinse, soap and water or wound cleanser - apply Hydrofera Blue and foam dressing - keep feet/wounds clean and dry at all times. - no foot soaks, whirlpools, or baths - resident was to wear a surgical boot and a Prevalon boot when in bed or wheelchair. R2's physician orders from a wound care provider dated March 25, 2026, indicated no changes to the current treatment. R2's Service Agreement signed February 13, 2023, did not include wound care, surgical boot,	01620		

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01620	Continued From page 22 or the Prevalon boot. R2's annual Service Plan Report dated November 19, 2025, was signed only by staff. The service plan was not signed by the resident or responsible party, nor did it include wound care, surgical boot, or the Prevalon boot. R2's Nursing Assessment and Level of Care Evaluation - AL - V3 uniform assessment dated November 19, 2025, did not include the wound, wound care, surgical boot, or the Prevalon boot. R2's Mini Level of Care Evaluation - AL - V3 dated February 17, 2026, did not include all required information in the uniform assessment, and it did not include an assessment of the wound, wound care, surgical boot, or the Prevalon boot. R2's Uniform Assessment Review - MN - AL - V2 dated February 17, 2026, did not include all required information in the uniform assessment and instead identified: "Attestation - No Change 1. I have reviewed all components of the Uniform Assessment as required and there have been no changes in the resident's condition." Although R2 had a new wound identified on January 31, 2026, and had new treatments of wound care and subsequently orthotics and changes to wound care, R2's record lacked evidence a change of condition assessment or on-going wound assessments were completed. On March 31, 2026, at 1:20 p.m., clinical nurse supervisor (CNS)-C stated R2 started wound care January 31, 2026, after an ER visit. Since R2's level of care did not change, a new uniform	01620		

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01620	Continued From page 23 assessment was not completed. CNS-C further stated a new wound would be a significant change to the resident's status but since her care level did not change, she had not completed a uniform assessment. She completed the level of care assessment on February 17, 2026, to verify there was no change in R2's level of care. The licensee's Change In Condition dated July 9, 2025, indicated the definition for a change in condition: "The resident has had a change from their baseline level of health, abilities and/or interactions with others." "Resident observations that may indicate a change in condition may be occurring" included "Wound/skin issue or changes in skin color". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	01640		

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01640	Continued From page 24 (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plan modifications were completed and signed when the resident's services changed for three of three residents (R2, R3, R5) as required. 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: R2 R2 was admitted on August 30, 2013, and began receiving assisted living services on August 1, 2021. On March 31, 2026, at 7:48 a.m., the surveyor observed unlicensed personal (ULP)-E completing wound care and applying an orthotic boot to R2's right foot. R2's emergency department report dated January	01640		

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01640	Continued From page 25 31, 2026, included the following: - R2 had a wound to the outer right foot with signs of infection. - dressings were applied to the wound and R2 was discharged with orders for antibiotics. R2's physician orders dated February 6, 2026, included Mepilex border foam change every three days and as needed. R2's physician orders from a wound care provider dated March 11, 2026, indicated R2 had surgical debridement of the right foot wound. Staff were to change the dressing to the wound every other day with the following instructions: - clean with saline rinse, soap and water or wound cleanser - apply Hydrofera Blue and foam dressing - keep feet/wounds clean and dry at all times. - no foot soaks, whirlpools, or baths - resident was to wear a surgical boot and a Prevalon boot when in bed or wheelchair. R2's Service Agreement signed February 13, 2023, did not include wound care, surgical boot, or the Prevalon boot. R2's annual Service Plan Report dated November 19, 2025, was signed only by staff and not the resident or responsible party. The service plan did not include wound care, surgical boot, or the Prevalon boot. Although R2 had a new wound identified on January 31, 2026, and had new treatments of wound care and subsequent orthotics and changes to wound care on March 11, 2026, R2's record lacked evidence a new service plan agreement or modification to the service plan was completed and signed agreement with the	01640		

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GOOD SAMARITAN SOCIETY-LUVERNE	201 OAK DRIVE LUVERNE, MN 56156

(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
01640	Continued From page 26 resident or responsible party was completed with the additional services. Although rate changes had occurred since the signing of the service agreement, a new service agreement or addendum had not been completed. R3 R3 was admitted on July 27, 2023, and received assisted living services. R3's Service Agreement was signed on July 28, 2023, indicating R3 received Level 3 services which included medication management, healthcare coordination, and included the fee for services. R3's Service Agreement did not include bathing assistance. On March 30, 2026, at 11:11 a.m., the surveyor observed ULP-D administering medications to R3. R3's documentation of services dated March 2026, included a whirlpool bath twice a week. R3's annual Service Plan Report dated July 29, 2025, included medication administration and bathing assistance. The Service Plan Report was signed by staff, but it was not signed by the resident or responsible party. Although rate changes had occurred since the signing of the service agreement, a new service agreement or addendum had not been completed. R5 R5 was admitted on February 9, 2024, and received assisted living services.	01640		

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01640	Continued From page 27 R5's Service Agreement was signed on February 2, 2024, and indicated R5 received Level 2 services including medication administration, bathing and included the fee for services. On March 31, 2026, at 12:51 p.m., clinical nurse supervisor (CNS)-C stated the Service Plan was updated annually and signed by staff. The Service Plan was not provided to or signed by the resident or their responsible party. CNS-C further stated if a resident's level of service didn't change, then she did not complete a new Service Plan Agreement or modification with the resident and/or responsible party. Although rate changes had occurred since the signing of the service agreement, a new service agreement or addendum had not been completed. On April 2, 2026, at 8:45 a.m., licensed assisted living director (LALD)-B stated the residents' Service Agreement includes what level of care the resident receives which can include multiple services available at that level, not necessarily the services that resident receives. The Service Plan Report accurately reflects the services the resident receives and it should be updated with changes and it should also be signed by the resident or their responsible party. In addition, there have been several rate changes since 2023, and one within the last year, when most of the Service Plan Agreements were signed; therefore, new Service Plan Agreements or addendums should have been signed with each rate change. A new service agreement or modification should have been completed when changes in services or fees were made.	01640		

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01640	Continued From page 28 The licensee's Resident Service Plan dated October 2, 2025 included "All assisted living community (ALC) residents must have a completed Service Plan. The Service Plan is created when the Level of Care Evaluation-AL or Nursing Assessment and Level of Care Evaluation-AL are completed in PCC [point click care]. The Service Plan must be printed and then signed and dated by the resident and the ALC manager or licensed nurse according to state regulations." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP)-E) were trained for medication administration and failed to ensure	01750		

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01750	Continued From page 29 medications were administered according to policy and accepted standards of practice. 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 is 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: ULP-E ULP-E was hired on November 15, 2025, and provided medication administration to the licensee's residents. ULP-E's record included a transcript for electronic training. ULP-E's transcript did not include medication administration training; however, ULP-E's record did include competency testing completed on November 24, 2025. On March 31, 2026, from 7:28 a.m. until 9:33 a.m., the surveyor observed ULP-E administering medications. The following concerns were identified: - medications were left on top of the medication cart and the medication cart was left unlocked when not in ULP-E's direct line of sight. - ULP-E handled medications with her bare hands to set up and during administration and did not wash hands after handling the pills. - ULP-E did not cue or assist residents to rinse their mouths after inhaler use - ULP-E did not measure diclofenac gel (used for pain) when administering it to R3	01750		

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01750	Continued From page 30 - medication administration errors of administering diclofenac to sites not included in the order, not properly measuring Citrucel resulting in the wrong dose, and administering fluticasone one spray in each nostril instead of two sprays in each nostril as ordered. On April 1, 2026, at 11:01 a.m., clinical nurse supervisor (CNS)-C stated the following: - staff should always have medications secured in the locked medication cart when unattended. - staff should not touch the pills without gloves on and should wash hand after touching medications if they are touched with a bare hand. - staff were trained to use the measuring strip when administering diclofenac gel - staff should apply the diclofenac to the ordered location and document the location in the MAR (medication administration record). - staff should have used measuring cup to measure the Citrucel - staff are trained to encourage or assist residents to rinse mouth and spit after using an inhaler On April 2, 2026, at 12:26 p.m., CNS-C stated the online training is what the staff complete for medication administration training and although ULP-E was assigned the medication training, she had not completed it. The licensee's Required Training for All Employees, Minnesota- Assisted Living policy dated March 17, 2026, indicated staff providing medication administration services would be trained and competency tested. No further information was provided. TIME PERIOD FOR CORRECTION: two (2) days	01750		

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01760	Continued From page 31	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to ensure medications were administered according to policy and accepted standards of practice for two of two residents (R6, R7). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6	01760		

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01760	Continued From page 32 On March 30, 2026, at 10:54 a.m., the surveyor observed ULP-D administering diclofenac to R6. ULP-C put some diclofenac on her gloved hand and administered to R6's right shoulder, right arm, upper middle back, and two fingers on R6's right hand. On March 31, 2026, at approximately 8:50 a.m., the surveyor observed the following: - ULP-E put some diclofenac on her gloved hand and administered to R6's right shoulder, and two fingers on the right hand and asked R6 if she wanted it applied anywhere else. - ULP-E brought R6's Citrucel (bowel movements) into R6's room. ULP-E used a regular teaspoon (not measuring spoon) and placed two spoonfuls pf Citrucel into a plastic cup. ULP-E then added water and mixed it. ULP-E encouraged R6 to drink the Citrucel and left the room. ULP-E documented it as administered, but did not observe R6 drink the mixture. - ULP-E administered fluticasone nasal spray 1 spray into each nostril. R6's Medication Administration Record (MAR) dated March 2026, included: - Diclofenac Sodium 1% gel apply to right shoulder topically three times a day related to pain (although the MAR indicated right shoulder, ULP-E had applied the gel to the right shoulder and fingers on the right hand) - Citrucel Oral Powder give 1 Tbsp (tablespoon) by mouth in the a.m. - fluticasone 2 sprays into both nostrils in the morning R6's physician orders dated January 22, 2026, included: - Diclofenac Sodium 1% gel apply to right	01760		

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01760	Continued From page 33 shoulder topically three times a day - Citrucel Oral Powder give 1 Tbsp (tablespoon) by mouth in the a.m. - fluticasone 2 sprays into both nostrils in the morning On March 31, 2026, at 9:33 a.m., ULP-E stated she had never been shown the diclofenac measuring strip and was unaware she needed to use it to measure the medication. R7 On March 30, 2026, at 11:05 a.m., the surveyor observed ULP-D administering the following to R7: - pHossident (dental health) put one lozenge into the medication cup. MAR indicated chew one lozenge four times a day. - ropinirole 2 mg take one tablet twice a day put in the same medication cup. ULP-D handed the medication cup to R7. ULP-D did not cue R7 to chew the pHossident. R7 swallowed both medications whole with a drink of water. R7's MAR dated March 2026, included pHossident fast melt lozenges chew one lozenge four times a day. R7's physician orders dated May 19, 2025, identified "We need [R7] to be taking his pHossident lozenges 4 times a day. He can either chew them or suck on them." On April 1, 2026, at 11:01 a.m., clinical nurse supervisor (CNS)-C stated the following: - staff were trained to use the measuring strip when administering diclofenac gel; - staff should apply the diclofenac to the ordered location and document the location in the MAR;	01760		

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01760	Continued From page 34 - staff should have used the medication cup to measure the Citrucel not a regular teaspoon; and - pHossident should have been administered as a chewable tab and resident should have been instructed to chew and swallow it. The licensee's Required Training for All Employees, Minnesota- Assisted Living policy dated March 17, 2026, indicated staff providing medication administration services would be trained and competency tested. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	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 interview and record review, the licensee failed to ensure documentation of medication setup was completed for the licensee's one resident (R10) receiving medication set-up services. 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	01770		

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01770	Continued From page 35 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: R10's MAR dated March 2026, included "NURSING ORDER: Pillbox set up one time a day every Wed (Wednesday)" and was signed off on March 25, 2026, by CNS-C. On April 1, 2026, at 11:55 a.m., clinical nurse supervisor (CNS)-C stated R10 received medication set up services and medication set up was signed off weekly on the medication administration record (MAR) which indicates the medications were set up. The documentation sign off did not include name of medication, quantity of dose, times to be administered, route of administration, and name of the person completing medication setup for each medication. CNS-C stated she was unaware each medication needed to be signed off upon medication set-up and documentation should include all required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is	01820		

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01820	Continued From page 36 managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain signed physician orders for medications administered for one of three residents (R9) and failed to have an order which included all required content for one resident (R6). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R9 On March 31, 2026, at 7:43 a.m., the surveyor observed unlicensed personnel (ULP)-E administer Calcium plus Vitamin D one tablet to R9. R9's physician's orders signed March 19, 2026, included cholecalciferol (Vitamin D) oral tablet 125 mcg (5000 IU) one tablet by mouth in the morning. On April 2, 2026, at 12:12 p.m., the surveyor received an email from clinical nurse supervisor (CNS)-C stating, "She [R9] came from the Oaks to us and we have been using up her OTC bottles; she does not have a calcium specific order from the doctor, but she was taking that	01820		

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01820	Continued From page 37 because it also had the Vit D in it [based off her Sanford chart order list]. She was previously independent with meds (medications) before moving to the AL (assisted living)" On April 2, 2026, at 3:58 p.m., CNS-C stated they should have had a physician order for the Calcium plus vitamin D. R6 On March 30, 2026, at 10:54 a.m., the surveyor observed ULP-D administering diclofenac to R6. ULP-C put some diclofenac on her gloved hand and administered to R6's right shoulder, right arm, upper middle back, and two fingers on the right hand. On March 31, 2026, at approximately 8:50 a.m., the surveyor observed the following: - ULP-E put some diclofenac on her gloved hand and administered to R6's right shoulder, and two fingers on the right hand and asked R6 if she wanted it applied anywhere else. R6's physician orders dated January 22, 2026, included: - Diclofenac Sodium 1% gel apply to right shoulder topically three times a day. The order did not include the dose. On April 2, 2026, at 11:42 a.m. CNS-C stated the diclofenac order should have included the dose. The licensee's Medication Administration and Supporting Process- [licensee location] AL policy dated March 6, 2026, indicated all medications administered to the residents must have a provider order. Diclofenac's prescribing information dated July	01820		

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01820	Continued From page 38 2009, included: - Use Voltaren® Gel exactly how your doctor prescribes it for you. Do not apply Voltaren® Gel anywhere other than where your doctor tells you to. - Do not use more than a total of 32 grams of Voltaren® Gel each day. This means that if you add up the amount of Voltaren® Gel as directed by your doctor, it should not be more than 32 grams in one day. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were securely locked permitting only authorized personnel to have access. This had the potential to affect all residents residing within the facility. 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	01880		

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01880	Continued From page 39 of the residents). The findings include: On March 31, 2026, during continuous observation beginning at 7:28 a.m. with ULP-E, the following was observed: - At 7:28 a.m. ULP-E set up medications for administration for R8. When placing the medication cards back into the cart, a levothyroxine (thyroid) pill fell from pharmacy card. ULP-E picked it up and noted the pill was missing from a different day and the glue holding the compartment shut, was loose. ULP-E placed it into the empty medication dose pack and placed it on the top of the cart, unsecured. ULP-E went into R8's room to administer medications, shutting the door behind her. The medication cart was not within ULP-E's line of sight, leaving it accessible to other staff, residents, and visitors. - at 7:43 a.m. ULP-E set up R9's medications for administration. ULP-E entered R9's room with the unsecured medication still sitting on top of the medication cart. The medication cart was not within ULP-E's sight, and accessible to other staff, residents, and visitors. - at 7:48 a.m. ULP-E set up R2's medications and wound care supplies and entered R2's room, closing the door behind her. ULP-E completed medication administration and wound care to R2. During that time, the unsecured medication was not within ULP-E's sight and was accessible to staff, residents, and visitors. - At 8:13 a.m. the surveyor left to complete another observation. - At 8:17 a.m. the surveyor returned to the medication cart and noted the pill was no longer on top of the cart, ULP-E stated she had given it to clinical nurse supervisor (CNS)-C.	01880		

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GOOD SAMARITAN SOCIETY-LUVERNE	201 OAK DRIVE LUVERNE, MN 56156

(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
01880	Continued From page 40 On March 31, 2026, at 8:42 a.m., ULP-E set up R5's medications for administration and entered R5's room, leaving the medication cart unlocked with R5's medications on top of the medication cart. The medication cart was not within ULP-E's line of sight and was accessible to staff, residents, and visitors. On April 1, 2026, at 11:02 a.m., CNS-C stated medications should always be securely stored in the locked medication cart and should not have been left unattended. The licensee's Medication Administration and Supporting Process- [facility city] AL policy dated January 26, 2026, included: "Storage Residents with Medication Administration services: ·Residents' medications are stored in locked cabinets in their apartments." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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:	01890		

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01890	Continued From page 41 Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date opened for three of three residents (R4, R8, R2) with inhalers and failed to ensure all medications had a pharmacy label for two of three residents (R8, R5) with inhalers. 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: R4 and R8 On March 30, 2026, at 11:32 a.m., the surveyor observed the medication cart with unlicensed personnel (ULP)-D and noted the following: - R4 had an Anoro Elipta inhaler open and in use, but it was not marked with an open date - R8 had a Breo Ellipta which had no pharmacy label and no open date. ULP-D stated she may have thrown the box with the pharmacy label away. R2 On March 31, 2026, at 7:48 a.m., the surveyor observed ULP-E setting up R2's medications for administration, and noted the following: - Docusate/senna two capsules PO (by mouth) two times a day - Eliquis 5 milligrams (mg) take one tab by mouth twice a day. The instructions were crossed out	01890		

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01890	Continued From page 42 and written on the label was "1/2 tab twice a day". R2's medication administration record (MAR) dated March 2026, included: - Stool Softener Laxative (docusate/senna) give one tablet by mouth in the morning. - Eliquis Oral Tablet 5 MG give 0.5 tablet by mouth every morning and at bedtime R5 On March 31, 2026, at 8:42 a.m., ULP-E removed R5's Breztri inhaler from the medication cart. The inhaler did not have a pharmacy label, did not have the box with a pharmacy label, and was not marked with an opened date. On March 30, 2026, at 11:43 a.m., clinical nurse supervisor (CNS)-C stated all medications should have had a pharmacy label. CNS-C further stated she was unaware inhalers were time sensitive. On April 1, 2026, at 11:17 a.m., CNS-C stated if a pharmacy label doesn't match the MAR, staff are required to notify the nurse so she can clarify. The Eliquis order changed, so she had changed the label. Anoro Ellipta prescribing information dated June 2019, included "Safely throw away ANORO ELLIPTA in the trash 6 weeks after you open the tray or when the counter reads "0", whichever comes first. Write the date you open the tray on the label on the inhaler." Breo Ellipta prescribing information dated May 2017, included "Safely throw away BREO ELLIPTA in the trash 6 weeks after you open the foil tray or when the counter reads "0", whichever comes first. Write the date you open the tray on the label on the inhaler."	01890		

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01890	Continued From page 43 Breztri prescribing information dated May 2017, included " BREZTRI AEROSPHERE should be discarded when the dose indicator display window shows zero or 3 months (for the 120-inhalation canister) or 3 weeks (for the 28-inhalation canister) after removal from the foil pouch, whichever comes first." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced	01910		

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01910	Continued From page 44 by: Based on interview and record review, the licensee failed to to include all required information on the disposition of medications for one of one discharged resident (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record included a Discharge Summary indicated R1 moved to a higher level of care on November 25, 2025. R1's disposition of medications dated December 1, 2025, included the following medications which did not include a prescription number as required: - latanoprost eye drops - dorzolomide eye drops - brimonidine eye drops On April 1, 2026, at 11:17 a.m., clinical nurse supervisor (CNS)-C stated R1 was transferred to the hospital and the eye drops were given to the hospital for administration there. CNS-C further stated there was no documentation of the transfer of the eye drops or the required content, which were sent to the hospital. The licensee's Disposition of Medication dated November 26, 2025, indicated If medications are released to a resident and/or responsible party at	01910		

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01910	Continued From page 45 the time of discharge, transfer or temporary leave of absence from the assisted living community (ALC), this will be done per provider's order, according to state regulations and documented as such in the resident care record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a licensed health professional instructed and specified, in	01950		

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01950	Continued From page 46 writing, specific instructions for administering a treatment for one of one resident (R2), and failed to ensure two of two unlicensed personnel (ULP)-D, ULP-E) were trained and competency tested for R2's treatment. 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 is 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 March 31, 2026, at 7:48 a.m., the surveyor observed R2 up and in her wheelchair. ULP-E removed R2's post operative shoe from her right foot, completed wound care and then replaced the post operative shoe. R2's physician orders dated March 11, 2026, indicated R2 had a wound to the right lateral foot, which was debrided. R2 was to wear a post operative shoe to the right foot. R2 was to wear a Prevalon boot to the right foot when in bed and in wheelchair, and was to be removed for transfers and showering. R2's Medication Administration Record (MAR) for March 2026, included: - "ortho shoe to right foot on during the daytime in the morning for right foot wound," and was signed off daily in the a.m. - "Prevalon boot on right foot at bedtime for right foot wound," and was signed off daily in the p.m.	01950		

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01950	Continued From page 47 R2's record lacked specific instructions for the two devices. ULP-D ULP-D was hired on March 4, 2024, and provided direct care services to the residents residing within the facility. ULP-D's employee record lacked evidence of training or competency testing for orthotic braces. ULP-E ULP-E was hired on November 15, 2025, and provided direct care services to the facility's residents. ULP-E's employee record lacked evidence of training or competency testing for orthotic braces. On April 2, 2026, at 8:57 a.m. clinical nurse supervisor (CNS)-C stated staff were not trained or competency tested for the orthotic shoe or the Prevalon boot. The licensee's Treatment And Therapy Management Services - Minnesota policy dated December 3, 2025, indicated educating employees about the administration of treatments or therapies currently ordered for the residents: A. When administration of a treatment or therapy is delegated to unlicensed personnel, the assisted living provider must ensure that the registered nurse or authorized licensed health professional has: i. Instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures. ii. Specified, in writing, specific instructions for each resident and documented those instructions	01950		

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01950	Continued From page 48 in the resident's record. iii. Communicated with unlicensed personnel about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	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 were administered as ordered for one of one resident (R2) receiving 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01960		

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01960	Continued From page 49 situation has occurred only occasionally). The findings include: On March 31, 2026, at 7:48 a.m., the surveyor observed ULP-E completing R2's wound care. ULP-E took out Hyrdofera foam dressing and cut a piece off and placed the rest back in the package. ULP-E removed the dressing on the right outer foot. R2 requested ULP-E spray JR Watkins lemon foaming soap to the wound. ULP-E sprayed the soap directly on the wound and the entire foot and used a dry rag to wipe it off. ULP-E did not rinse the soap off. ULP-E then used wound spray on the wound and changed gloves. ULP-E placed the Hydrofera Blue dressing and covered with a foam dressing. R2 requested ULP-E use sterile saline on the wound. ULP-E went to the medication cart, removed an open pink vial which had tape on the top of it, removed the tape, removed the dressing, sprayed some on the wound and taped the vial shut again so it "won't leak". ULP-E then replaced the dressing on the wound, placed a 4x4 gauze and taped the dressing to R2's foot. ULP-E then put nylons on R2 and placed an surgical boot on R2's foot. ULP-E documented the wound care and documented she applied compression stockings. R2's wound care clinic orders dated March 11, 2026, included the following: - cleanse wound using normal saline, wound cleanser, or soap and water. R2's physician orders dated January 26, 2026, included compression hose to bilateral lower extremities on in the morning and off at night for edema. R2's medication administration record (MAR)	01960		

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01960	Continued From page 50 dated March 2026, included: - Right Foot Wound: cleanse with wound cleaner & gauze; Cut Hydrofera blue to fit inside wound bed and cover with foam dressing. Change every other day. - compression hose to bilateral lower extremities on AM and off at bedtime On April 1, 2026, at 11:02 a.m., clinical nurse supervisor (CNS)-C stated staff should have followed the wound care instructions as listed on the MAR. If R2 requested the soap and saline, staff should have called the nurse for guidance as that is not what is on the MAR. Staff should have applied compression hose, not nylons. If R2 refused the compression hose and requested nylons, then staff should have documented that; not that compression hose had been applied. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one	02310		

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02310	Continued From page 51 resident (R12) with a consumer grab bar. This resulted in an immediate order issued on April 1, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R12 was admitted on June 14, 2025, with diagnoses including spinal stenosis, urinary urgency with incontinence, chronic kidney disease, osteoarthritis, and obstructive sleep apnea. R12's Service Agreement dated June 14, 2025, indicated R12's services included bathing and medication administration. R12's Resident Evaluation for Assist Grab Bars assessment dated December 22, 2025, indicated R12 used the grab bar to assist in getting in and out of bed and assist with turning and repositioning. Assist grab bar information included this statement "slide under the mattress style assist bar with legs no manufacturer information attached". Although the licensee did not have the manufacturer's information for the grab bar, the assessment indicated a copy of the manufacturer information was in R12's record, it was installed according to manufacturer guidelines and the assist grab bar had no recalls with the consumer product safety commission	02310		

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02310	Continued From page 52 (CPSC). Additional direction/educations included "understands that her bedrail is not installed appropriately and therefore poses a significant entrapment risk that could lead to death. RN provided information on the M-rail [the grab bar in use is not an M-Rail] and education. Resident refuses to remove her current bedrail. Resident verbalizes understanding of this risk." R12's Resident Evaluation for Assist Grab Bars dated March 31, 2026, after the surveyor entered the facility, and 99 days after the previous assessment, indicated R12 used the grab bar to assist in getting in and out of bed and assist with turning and repositioning. Assist grab bar information included this statement "slide under the mattress style assist bar with legs no manufacturer information attached". Although the facility did not have the manufacturer's information for the grab bar, the assessment indicated a copy of the manufacturer information was in R12's record, it was installed according to manufacturer guidelines and the assist grab bar had no recalls with the CPSC. Additional direction/educations included "understands that her bedrail is not installed appropriately and therefore poses a significant entrapment risk that could lead to death. RN provided information on the M-rail [the grab bar in use is not the M-Rail] and education. Resident refuses to remove her current bedrail. Resident verbalizes understanding of this risk." R12's Documentation Survey Report dated March 2026, indicated staff did a service of "Bedrail/Assist Bar check every evening." There was no description as to what the staff were to do when checking the assist bar. On April 1, 2026, at 11:50 a.m., clinical nurse	02310		

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02310	Continued From page 53 supervisor (CNS)-C stated the licensee's corporate nurse would send notifications regarding any recalls that were announced for bed rails/grab bars, but nothing specific to the bedrails used in the facility. CNS-C further stated she does not check the CPSC for recalls on consumer bed rails/grab bars. On April 1, 2026, at 12:08 p.m., the surveyor observed R12's consumer grab bar with CNS-C. The grab bar was U-shaped with legs down to the floor and a U-shaped bar that went between the mattress and the bed frame. The grab bar easily slid in and out, and was not secured to the bed. CNS-C stated the rail is not an M-rail type rail. In addition, there was not manufacturer information available for the bed rail, so they were unable to ensure correct installation, and they would not be able to check for recalls. On April 1, 2026, at 12:50 p.m., licensed assisted living director (LALD)-B stated the staff are checking off daily that they check the grab bar, but there is no description as to what that entails. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The MDH website, Assisted Living Resources &	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20465	A. BUILDING: _____ B. WING _____	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-LUVERNE	201 OAK DRIVE LUVERNE, MN 56156

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02310	Continued From page 54 FAQs indicated licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CPSC) for the most up-to-date information related to portable bed side rail recall information. To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The licensee's Assist Grab Bar Use, AL Enterprise policy dated August 20, 2025, included 4. If a consumer bed system is in use, it must be	02310		

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GOOD SAMARITAN SOCIETY-LUVERNE	201 OAK DRIVE LUVERNE, MN 56156

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02310	Continued From page 55 installed to the resident's bed according to manufacturer specific guidelines. The completion and documentation of specific resident assessments, education regarding assist grab bar risks and benefits and an evaluation of assist grab bar safety is required when an assist grab bar is in use. The assist grab bar must be designed to work with the bed "system" including the bed frame and mattress. A. A loose or "wobbly" assist grab bar will not be used. B. An assist grab bar designed for youth or children will not be used. C. An assist grab bar is not allowed unless manufacturer ' s recommendations for use can be supplied and determined appropriate." The AL nurse will be responsible to carry out the following steps regardless of whether the assist grab bar was provided and/or installed by a third-party provider (such as durable medical equipment companies, home health or hospice): A. The AL nurse will assess the resident's bed type to ensure the rail has been installed according to manufacturer guidelines. i. Any bed system where the bed is manually, hydraulically or electrically adjusted should be considered a hospital bed system until otherwise proven. Hospital bed systems must be obtained from a reputable source and have all components approved or supplied by the manufacturer" The nurse will document the above assessments and actions on the Resident Evaluation for Assist Grab Bars-AL according to the following intervals: A. Prior to bed rail/assist grab bar initiation B. Every 90 days (MN locations only) C. Upon a significant change in condition, and D. Annually	02310		

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02310	Continued From page 56 9. A bed rail/assist grab bar that does not meet the specific zone measurement recommendations listed above or is not installed according to manufacturer guidelines will require further action. If education does not convince the resident and/or the resident ' s representative of the inherent entrapment risks associated with the continued use of a nonconforming bed rail/assist grab bar, the following options may be provided to the resident and/or the resident ' s representative by the AL nurse or senior living manager. A. Remove the assistive device. B. Highly encourage selection of a safer assist grab bar option that meets the appropriate measurement requirements of the FDA/manufacturer guidelines. C. If neither of the above actions are acceptable to the resident and/or the resident ' s representative, contact the Senior Living Consultant to discuss options. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The licensee took immediate action to mitigate risk; however, the scope and level remains at l.	02310		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.	02320		

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02320	Continued From page 57 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP)-D, ULP-E) administered diclofenac gel (pain relief) per manufacturer guidelines and failed to ensure one of one ULP (ULP-E) administered oral medications per accepted health care, medical and nursing standards and per the facility policy. 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: Diclofenac gel On March 30, 2026, at 10:58 a.m., the surveyor observed ULP-D put on gloves, expose R6's right shoulder, and without using the measuring device, applied diclofenac gel to her gloved hand, and apply it to the right shoulder. ULP-D then applied more diclofenac gel to her gloved hand and applied to R6's first and second fingers of the right hand. Lastly, ULP-D lifted the back of R6's shirt, put more diclofenac gel to her gloved hand and applied it R6's upper mid back. On March 31, 2026, at approximately 8:50 a.m., the surveyor noted the following: - ULP-E put some diclofenac on her gloved hand without using the measuring device, and administered to R6's right shoulder and two	02320		

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02320	Continued From page 58 fingers on the right hand. ULP-E then asked R6 if she wanted it applied anywhere else. R6's physician orders dated July 16, 2025, included diclofenac gel apply to right shoulder three times a day. R6's MAR dated March 2026, included diclofenac gel apply to right shoulder three times a day. On March 31, 2026, at 9:33 a.m., ULP-E stated she had never been shown the diclofenac measuring device and was unaware she needed to use it to measure the medication. On April 1, 2026, at 11:01 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to use the measuring strip when administering diclofenac gel and they should have used it to properly administer the medication. ULP-E On March 31, 2026, the surveyor observed ULP-E administering medications and noted the following: - 7:48 a.m. ULP-E removed the Preservision capsule from the medication cup with her ungloved hand, stating R8 likes to take this one separately. R8 took the other pills and ULP-E placed the capsule back into the medication cup and R8 took it. ULP-E did not wash her hands after touching the capsule. - 7:43 a.m. ULP-E was setting up R9's medications to administer. ULP-E reached her ungloved finger into the calcium bottle and removed a pill and placed it into the medication cup. ULP-E did not wash her hands after touching the medication. - 7:48 a.m. ULP-E was setting up R2's medications to administer. ULP-E reached her	02320		

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02320	Continued From page 59 ungloved finger into the docusate and vitamin D3 bottles to remove pills and placed them into the medication cup for administration. ULP-E did not wash her hands after touching the medications. On April 1, 2026, at 11:02 a.m., CNS-C stated when administering medications, staff should have removed medications from the bottles using the cap or apply gloves if they were going to touch the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

GOOD SAMARITAN SOCIETY LUVERNE
201 OAK DRIVE
Luverne, MN 56156
Rock
Parcel:

Phone:

License Info

License: HFID 20465

Risk:
License:
Expires on:
CFPM: McKenzie T. Sprecher
CFPM #: 123411; Exp: 5/2/2027

Inspection Info

Report Number: F7990261005
Inspection Type: Full - Single
Date: 3/31/2026 Time: 10:46:58 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

WE DISCUSSED EMPLOYEE ILLNESS, COOLING, HANDWASHING, AND NOROVIRUS PREVENTION. AN EMPLOYEE ILLNESS LOG IS KEPT ONSITE.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Mankato District Office inspection report number F7990261005 from 3/31/2026

Benjamin D. Ische

McKenzie Sprecher

Ben Ische,
Public Health Sanitarian Supervisor
507-344-2710
ben.ische@state.mn.us

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Establishment Info

GOOD SAMARITAN SOCIETY LUVERNE
Luverne
County/Group: Rock

Inspection Info

Report Number: F7990261005
Inspection Type: Full
Date: 3/31/2026
Time: 10:46:58 AM

Food Temperature: Product/Item/Unit: Diced Chicken Arctic Air Reach In**; Temperature Process:** Cold-Holding
Location: Reach-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk Traulsen Reach In Cooler**; Temperature Process:** Cold-Holding
Location: Reach-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Sanitizer Observations/Recordings

Establishment Info

GOOD SAMARITAN SOCIETY LUVERNE
Luverne
County/Group: Rock

Inspection Info

Report Number: F7990261005
Inspection Type: Full
Date: 3/31/2026
Time: 10:46:58 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Greater Than** 160 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** Wiping Cloth Bucket
Location: Dishwashing Area **Equal To** 700 PPM
Comment:
Violation Issued?: No