DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 4, 2024

Licensee
Good Samaritan Society - Albert Lea
75303 240th Street
Albert Lea, MN 56007

RE: Project Number(s) SL30517015

Dear Licensee:

On October 29, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 31, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Electronically Delivered

August 26, 2024

Licensee
Good Samaritan Society - Albert Lea
75303 240th Street
Albert Lea, MN 56007

RE: Project Number(s) SL30517015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 31, 2024, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30517	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBER	75303 240TH STREET ALBERT LEA, MN 56007

(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: SL30517015-0 On July 29, 2024, through July 31, 2024, 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 72 resident(s); 38 receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 1 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by 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 observation, 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 documentation of a completed health history and symptom screening, for one of two employees (unlicensed personnel (ULP)-B). 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:	0 660		

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0 660	Continued From page 2 The facility's TB risk assessment dated September 7, 2023, indicated the licensee was "low risk". ULP-B began providing direct care service for the licensee on January 10, 2023. On July 30, 2024, at 7:53 a.m. ULP-B was observed to administer scheduled oral medications to R2 in his room. ULP-B's record contained a negative one step tuberculin skin test (TST) dated June 26, 2021, and a second step TST dated July 10, 2021; however, ULP-B's employee record lacked a TB history and symptom screen. On July 31, 2024, at 8:10 a.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated ULP-B was lacking a TB history and symptom screen. The licensee's Tuberculosis Control Plan and Screening for Employees, Senior Living, Rehab/Skilled, Home Health, Child Day Enterprise policy dated reviewed/revised December 7, 2023, noted prior to or upon hire, all employees will be screened for TB risk and for signs or symptoms of active TB disease. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may	0 660		

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0 660	Continued From page 3 be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident's records were authenticated by the title of the nurse making the entry for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2	0 690		

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0 690	Continued From page 4 R2's Nursing Assessment and Level of Care Evaluation identified as a pre-admission assessment dated October 5, 2023, was not authenticated with the title of the person completing the assessment. R2's Uniform Assessment Review, identified as 90-day reviews dated January 18, 2024, April 5, 2024, and July 26, 2024, were not authenticated with the title of the person completing the assessment. R3 R3's Nursing Assessment and Level of Care Evaluation dated October 19, 2023, was not authenticated with the title of the person completing the assessment. R3's Uniform Assessment Review identified as 90-day reviews dated February 28, 2024, and May 28, 2024, were not authenticated with the title of the person completing the assessment. R4 R4's Nursing Assessment and Level of Care Evaluation dated December 15, 2023, was not authenticated with the title of the person completing the assessment. R4's Uniform Assessment Review identified as 90-day reviews dated February 23, 2024, and May 23, 2024, were not authenticated with the title of the person completing the assessment. On July 31, 2024, at 3:27 p.m. clinical nurse supervisor/licensed assisted living director CNS/LALD-A reviewed R2's assessments as noted above and stated they had not been authenticated with her nursing title. CNS/LALD-A stated her nursing credentials were not set up in	0 690		

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0 690	Continued From page 5 their computer system to populate correctly and indicated this would affect all resident assessments she had completed at the facility. The licensee's Legal Documentation Standards policy dated as reviewed/revised January 6, 2022, included entries in the medical record are authenticated by a signature. At a minimum, the license signatures will include first initial, last name and title/credential. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780		

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0 780	Continued From page 6 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: On a facility tour on July 9, 2024, between 12:30 p.m. and 3:30 p.m. at the Bancroft Creek Estates Facility with the maintenance technician (MT)-E the MT-E removed a couple of smoke alarms. The surveyor observed that some of the resident room smoke alarms were over 10 years old from date of manufacture. The surveyor explained to the MT-E that smoke alarms over 10 year sold from date of manufacture shall be replaced with like type alarms. In this case, 120-volt, battery backup and interconnected if required with other alarms in the	0 780		

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0 780	Continued From page 7 residence. The deficient condition was visually verified by the MT-E accompanying on the tour. On a facility tour on July 9, 2024, between 10:00 a.m. and 12:30 p.m. with the maintenance technician (MT)-E at the Hidden Creek Facility the MT-E removed a couple of smoke alarms. The surveyor observed that some of the resident room smoke alarms were over 10 years old from date of manufacture. The surveyor explained to the MT-E that smoke alarms over 10 year sold from date of manufacture shall be replaced with like type alarms. In this case, 120-volt, battery backup and interconnected if required with other alarms in the residence. The deficient condition was visually verified by the MT-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800		

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0 800	Continued From page 8 by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the facility tour on July 30, 2024, with maintenance technician (MT)-E, between 12:30 p.m. and 3:30 p.m. at the Bancroft Creek Estates Facility the following facility hazards and disrepair were observed: FIRE DOORS: The surveyor observed several fire doors that were propped open, had a various devices holding them open and that most resident room and laundry room doors had their closures removed. Several other fire doors throughout the facility did not close and latch under their own power. All doors to the corridors or stairwells shall close and latch under their own power. The surveyor explained to MT-E, that all doors to the corridor must meet the state statute for fire doors and the fire rating shall be always	0 800		

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0 800	Continued From page 9 maintained. EMERGENCY/EXIT LIGHTS: The surveyor observed some of the exit/emergency lights failed to operate when push button tested by MT-E. The surveyor explained to MT-E that all emergency/exit lights shall operate when push button tested, be push button tested monthly, the 30-minute test completed annually, documented and shall comply with the Minnesota State Fire Code. BUIDLING MAINTENANCE: The surveyor noted when reviewing the Olympic Fire Protection annual report dated 9-7-23 for the fire sprinkler system, deficiencies noted for 5 year internal piping inspection, outside horn/strobe did not operate when tested and that the hydraulic calculations were missing on the riser(s) The surveyor explained to MT-E that all noted deficiencies shall be fixed. The surveyor observed the ceiling tiles outside resident room 118 were wet and showed signs of mold. The surveyor explained to the MT-E that the ceiling tile shall be replaced. The surveyor observed that the rated ceiling assembly inside mechanical/storage room 111 had be compromised. The ceiling had been opened up to fix a leak and had not been patched up.	0 800		

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0 800	Continued From page 10 The surveyor explained to the MT-E that the ceilings in fire rated assemblies must be maintained without unprotected openings. The deficient conditions were visually verified by the MT-E accompanying on the tour. During the facility tour on July 30, 2024, with maintenance technician (MT)-E, between 10:00 a.m. and 12:30 p.m. at the Hidden Creek Facility the following facility hazards and disrepair were observed: FIRE DOORS: The surveyor observed several fire doors that were propped open, had a various devices holding them open. The kitchen door to the dining room and the laundry room doors did not close and latch under their own power. All doors to the corridors or stairwells shall close and latch under their own power. Several resident room doors were propped open. The surveyor explained to MT-E, that all doors to the corridor must meet the state statute for fire doors and the fire rating shall be always maintained. EMERGENCY/EXIT LIGHTS: The surveyor observed some of the exit/emergency lights failed to operate when push button tested by MT-E. The surveyor explained to MT-E that all emergency/exit lights shall operate when push button tested, be push button tested monthly, the 30-minute test completed annually, documented and shall comply with the Minnesota State Fire	0 800		

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0 800	Continued From page 11 Code. BUIDLING MAINTENANCE: The surveyor noted when reviewing the Olympic Fire Protection annual report dated 9-7-23 for the fire sprinkler system, deficiencies noted for 5 year internal piping inspection, outside horn/strobe did not operate when tested and that the hydraulic calculations were missing on the riser(s) The surveyor explained to MT-E that all noted deficiencies shall be fixed. The deficient conditions were visually verified by the MT-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced	0 820		

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(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
0 820	Continued From page 12 by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On July 30, 2024, between 10:00 a.m. and 12:30 p.m., the surveyor toured the facility with the maintenance technician (MT)-E and the following was observed: Patio exit door: The patio door had an exit sign posted on it and this door was designated as an emergency exit on the posted evacuation map. There was a magnetic lock on the interior side of this door that required entry of a code into a keypad beside the door to exit. Northeast exit door: The northeast was designated as an emergency exit on the posted evacuation map. There was a magnetic lock on the interior side of this door that required entry of a code into a keypad beside the door to exit.	0 820		

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	30517	A. BUILDING: _____ B. WING _____	07/31/2024

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GOOD SAMARITAN SOCIETY - ALBER	75303 240TH STREET ALBERT LEA, MN 56007

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0 820	Continued From page 13 Southeast exit door: The southeast side exit door was designated as emergency exits on the posted evacuation map. There was a magnetic lock on the interior side of this door that required entry of a code into a keypad beside the door to exit. The deficient conditions were visually verified by the MT-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) 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; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety,	01370		

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01370	Continued From page 14 and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for one of two employees (unlicensed personnel (ULP)-B) as required prior to providing direct care. 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-B had a hire date of January 10, 2023, to provide services under the licensee's assisted living license.	01370		

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01370	Continued From page 15 ULP-B's employee record lacked evidence to indicate the employee completed training and/or practical skills evaluations as required in the following areas: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; and - maintenance of a clean and safe environment. ULP-B's employee record contained a transcript which listed various training topics; however, the transcript lacked evidence of the above required topics. On July 31, 2024, at 3:20 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the above topics were lacking from ULP-B's employee file. CNS/LALD-A stated ULP-B had transferred to direct care from the dietary department and these learning topics had not been assigned to ULP-B. The licensee's Required Training for All Employees policy dated reviewed/revised July 8, 2024, included: 2. In addition to Society staff member training requirements, training and competency evaluations for all ULP 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 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01370		

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01370	Continued From page 16 (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations contained all the required training for one of two unlicensed personnel (ULP-B). 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).	01380		

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01380	Continued From page 17 The findings include: ULP-B had a hire date of January 10, 2023, to provide services under the licensee's assisted living license. ULP-B's employee record lacked evidence of training to include the following required content: - observing, reporting, and documenting resident status; and - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. On July 31, 2024, at 3:20 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the above topics were lacking from ULP-B's employee file. CNS/LALD-A stated ULP-B had transferred to direct care from the dietary department and these learning topics had not been assigned to ULP-B. The licensee's Required Training for All Employees policy dated reviewed/revised July 8, 2024, included: 3. Training and competency evaluation for ULP providing assisted living service 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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 be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the nurse completed a resident assessment within 14 days of admission for one of three residents (R2) and ongoing resident reassessments that did not exceed 90 days for one of three residents (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	01620		

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01620	Continued From page 19 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 and began receiving assisted living services on November 6, 2023. R2's Service Agreement dated November 10, 2023, indicated R2 received services including assistance with bathing, grooming, dressing, and medication assistance four to six times daily. R2's record included a Nursing Assessment and Level of Care Evaluation identified as a pre-admission assessment dated October 5, 2023, and a subsequent assessment dated November 29, 2023. The November 29, 2023, assessment was 23 days after the date of R2's admission, exceeding 14 calendar days. In addition, R2's record included 90-day Uniform Assessment Review assessments dated April 5, 2024, and July 26, 2024. The July 26, 2024, assessment was 112 days from the last date of the assessment on April 5, 2024, exceeding 90 calendar days. On July 31, 2024, at 3:23 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R2's 14-day assessment and 90-day assessment were completed late as noted above. The licensee's Resident Assessment policy dated reviewed/revised May 29, 2024, noted the Level	01620		

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01620	Continued From page 20 of Care Evaluation or Nursing Assessment and Level of Care Evaluation will be completed by a licensed nurse (licensed practical nurse or registered nurse as required by state assisted living and board of nursing regulations) for each resident prior to or upon admission, annually, and upon significant change in condition. Some states may require additional periodic evaluations; refer to state specific regulations. The licensee's Resident Medical Record Documentation policy dated reviewed/revised April 5, 2024, included: 2. An initial pre-admission assessment must be conducted by a registered nurse (RN) on all prospective residents before the occupancy agreement is signed. 3. A uniform assessment must be completed, and the service plan finalized within 14 calendar days after initiation of services. 5. Residents must be reassessed or reviewed by an RN as needed based on changes in the residents' needs and cannot exceed 90 calendar days from the last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	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	01640		

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01640	Continued From page 21 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. (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 a written service plan was revised to reflect the current fees and services provided for one of three residents (R4). 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: R4's physician orders dated May 8, 2024, included an order for Lifestyle Comfort Socks (compression stockings), apply to lower extremity	01640		

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01640	Continued From page 22 daily, remove before bed. On July 30, 2024, at 8:43 a.m. unlicensed personnel (ULP)-C was observed applying compression stockings to R4's lower legs. R4's Tasks Completed form dated July 2024, indicated staff assisted R4 twice daily with compression stockings. R4's Service Agreement signed July 21, 2021, indicated R4 received medication management services and assistance with activities of daily living; it further indicated the fees for services. The service agreement did not include assistance with compression stockings. R4's service plan signed May 26, 2022, indicted staff provided cueing and hands-on assist with AM and/or PM dressing/undressing. The service plan did not include R4's prescribed compression stockings. On July 31, 2024, at 11:23 a.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the service agreement and service plan go together. CNS/LALD-A reviewed R4's service agreement/service plan and stated compression stockings had not been included on either one. CNS/LALD-A further stated R4's payer source had changed last fall and thus the fee for services on the service agreement was inaccurate. The licensee's Resident Service Plan policy dated October 24, 2023, indicated: H. The Service Plan is updated according to changes in the resident assessment and condition, at least annually or per state regulations.	01640		

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01640	Continued From page 23 No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered	01730		

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01730	Continued From page 24 as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current individualized medication management plan with the required content for three of three residents (R3, R4, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on July 29, 2024, at 9:49 a.m. clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A confirmed the licensee provided medication management services to the residents at the facility. R3 R3's diagnoses included epilepsy (seizure	01730		

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01730	Continued From page 25 disorder), type two diabetes, atrial fibrillation, and depression. R3's Service Agreement signed July 15, 2021, indicated R3 received medication administration. R3's Medication Administration Record (MAR) dated July 2024, included two medications for diabetes, one antidepressant, one anticonvulsant (for seizures), two heart medications, and two diuretics (for edema). R4 R4's diagnoses included multiple sclerosis, seizure disorder, atrial fibrillation, and constipation. R4's Service Agreement signed July 13, 2021, indicated R4 received medication administration. R4's physician orders dated May 8, 2024, included one laxative, one anticonvulsant, one blood thinner, two heart medications, and three medications for pain. R3, and R4's individual medication management plans lacked: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. On July 31, 2024, at 2:34 p.m. CNS/LALD-A reviewed the above Medication Management plans and stated they did not include the above required content. R2 R2's diagnoses included cerebral infarction	01730		

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GOOD SAMARITAN SOCIETY - ALBER	75303 240TH STREET ALBERT LEA, MN 56007

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01730	Continued From page 26 (stroke), bilateral cataract (clouded, blurred, or dim vision), glaucoma (high pressure in the eye leading to vision loss and blindness), osteoarthritis (form of arthritis affecting any joint and causes pain, stiffness, and loss of mobility), and dementia (loss of cognitive functioning). R2's Service Agreement dated November 10, 2023, indicated R2 received services including medication assistance four to six times daily. The care plan (identified as the service plan and part of the service agreement and medication management plan) identified R2 was independent with self-administration of medications and medications would be kept in a secure area within his room to prevent medication theft and diversion. On July 30, 2024, at 7:53 a.m. unlicensed personnel (ULP)-B was observed to administer scheduled oral medications to R2 in his room. All medications were prepared from the locked medication cart by ULP-B. R2's prescriber orders dated June 12, 2024, included two medications for blood pressure, one diuretic (for edema), one for anxiety, one for gastric reflux, one for allergies, one mild to moderate pain pill, and one for Parkinson's disease. R2 prescriber orders dated October 16, 2023, included two eye drops for glaucoma. R2's July 2024, MAR listed medications as prescribed, times to administer, and staff initials through July 29, 2024, to indicate the medications had been given. R2's individual medication management plan lacked an accurate description of storage of medications based on the resident's needs and	01730		

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01730	Continued From page 27 preferences, risk of diversion, and consistent with the manufacturer's directions. On July 31, 2024, at 3:28 p.m. CNS/LALD-A reviewed R2's medication management plan and stated it was inaccurate as noted above. A policy on medication management was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=E	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, the licensee failed to ensure as needed (PRN) medications had documentation of effectiveness after administration for one of four	01760		

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01760	Continued From page 28	01760		

residents (R2). In addition, the licensee failed to ensure prescriber orders were transcribed as ordered for two of four residents (R2, R4), and failed to ensure medications were administered as prescribed for one of five residents (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 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:

PRN DOCUMENTATION/EFFECTIVENESS
R2's prescriber orders dated June 12, 2024, included acetaminophen extra strength 500 milligrams (mg) two tablets by mouth every eight hours as needed for pain.
R2's prescriber order dated May 28, 2024, included Asperflex (for arthritis pain) 4% patch to area of pain (knee).
R2's prescriber order dated January 29, 2024, included lorazepam 0.5 mg by mouth every four hours as needed for anxiety/restlessness.
Morphine sulfate 20 mg/milliliter (ml) give 0.25 ml by mouth or under tongue every two hours as needed pain/shortness of breath.

R2's Service Agreement dated November 10, 2023, indicated R2 received services including medication assistance four to six times daily.

R2's June 2024, Medication Administration Record (MAR) identified the administration of the

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01760	Continued From page 29 following: - June 14, 2024, June 23, 2024, and June 28, 2024, lorazepam administered with no documentation of the time administered or effectiveness. June 24, 2024, had documentation of the medication administered but no effectiveness. - June 20, 2024, morphine administered with no documentation of the time administered or effectiveness. R2's July 2024, MAR identified the administration of the following: - July 2, 2024, July 4, 2024, and July 8, 2024, Asperflex 4% patch applied with no documentation of the time administered or effectiveness. July 6, 2024, had documentation of the medication administered but no effectiveness. - July 27, 2024, acetaminophen administered with no documentation of the time administered or effectiveness. - July 28, 2024, lorazepam administered with no documentation of the time administered or effectiveness. On July 31, 2024, at 3:34 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R2's PRN medications lacked the required documentation and stated staff were expected to document the time the medications were administered and a follow-up for the effectiveness of the medications. TRANSCRIPTION OF PRESCRIBER'S ORDERS R2 R2's prescriber orders dated June 17, 2024, included orders for:	01760		

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01760	Continued From page 30 - diclofenac topical 1% gel apply two grams (using dosing card) topically to affected area four times daily for arthritis or pain; - pramoxine topical 1% lotion apply thin layer topically to the affected area three times daily as needed for rash/itching. On July 30, 2024, at 8:08 a.m. ULP-B was observed to apply pramoxine (anti-itch lotion) to R2's back, chest, and arms. ULP-B stated there was nowhere to chart the pramoxine and indicated it was part of R2's morning care documentation. R2's June 2024, and July 2024, MAR did not include either order. On July 31, 2024, at 3:34 p.m., CNS/LALD-A stated R2's order for diclofenac and pramoxine had not been transcribed or implemented to the MAR as ordered. R4 R4's prescriber orders dated May 8, 2024, included: trolamine salicylate (Aspercreme) 10% cream as directed to skin three times a day as needed for pain. Apply to affected area PRN for muscle/joint pain. R4's MAR dated July 2024, did not include the above order. The MAR did include: Aspercreme with lidocaine 4% Apply TOP (topically) to right knee 3x/day (three times a day) PRN pain. On July 31, 2024, at 2:34 p.m. CNS/LALD-A reviewed R4's current physician orders and July 2024, MAR. CNS/LALD-A stated the order for Aspercreme was an old order R4 hadn't been using and hadn't asked to have it renewed. CNS/LALD-A further stated the Aspercreme with	01760		

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01760	Continued From page 31 lidocaine 4% was a topical patch R4 used to have an order for, but hadn't utilized for a long time. CNS/LALD-A stated the patch was not included in the current orders and should have been removed from R4's MAR. DOCUMENTATION OF ADMINISTRATION OF MEDICATIONS R6 On July 30, 2024, at 8:23 a.m. ULP-B was observed to prepare and administer medications to R6. After ULP-B prepared and obtained all oral medications into a medication cup, she stated R6 would want her arthritis cream applied and obtained R6's Aspercreme 10% cream from the medication cart and brought into R6's room. R6 stated she has staff apply the arthritis cream daily to her hips. ULP-B then administered the oral medications to R6, applied a glove and rubbed the Aspercreme to R6's bilateral hips. Following this, ULP-B removed her glove, sanitized her hands, and documented the oral medications on the MAR. The surveyor inquired where the Aspercreme was documented, and ULP-B stated it was not on the MAR. The surveyor assisted ULP-B to identify trolamine salicylate as a generic name for Aspercreme and ULP-B documented. ULP-B stated she had not been documenting the Aspercreme because she did not think it was identified on the MAR. On July 31, 2024, CNS/LALD-A stated staff should be documenting use of medications as requested by the resident and indicated both generic and trade names should be listed on the MAR. The licensee's Medication Administration and Supporting Processes policy dated reviewed/revised September 5, 2023, noted	01760		

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01760	Continued From page 32 orders would be transcribed onto the MAR by the licensed nurse or resident assistant/medication aide (who has been trained) if order meets the qualifications of a complete physician order (resident name, medication name, dose, directions including route, frequency, date and physician's signature). Orders will be transcribed onto MAR exactly as it is written by the physician. The policy further directed medications may be administered by licensed nurses and/or ULP properly trained according to state regulations. The policy did not address the use of PRN medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider had managed for one of three residents (R4). 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	01820		

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01820	Continued From page 33 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: R4's diagnoses included constipation. R4's service plan signed May 26, 2022, included medication administration. R4's Medication Administration Record (MAR) dated July 2024, included: Senna S (laxative) 8.6-50 mg (milligrams) Take one tablet by mouth daily PRN (as needed) constipation. On July 30, 2024, at 7:37 a.m. unlicensed personnel (ULP)-G was observed administering medications to R4. R4's current prescriber orders dated May 8, 2024, included: Stimulant Laxative Plus 8.6-50 mg, one tablet by mouth once a day. The prescriber orders did not include an order for a PRN dose. On July 31, 2024, at 2:34 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R4 used to have a PRN order for the Senna S laxative but didn't use it. CNS/LALD-A further stated there was no longer a PRN order and it should have been removed from R4's MAR. The licensee's Medication Administration and Supporting Processes policy dated September 5, 2023, indicated: Any medication discontinued will be noted on the MAR, by writing "DCd", the date and initials. This area on the MAR will also be	01820		

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01820	Continued From page 34 highlighted out with blue highlighted. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=D	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 stored securely for one of five residents (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's diagnoses included cerebral infarction (stroke), bilateral cataract (clouded, blurred, or dim vision), glaucoma (high pressure in the eye leading to vision loss and blindness), osteoarthritis (form of arthritis affecting any joint	01880		

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01880	Continued From page 35 and causes pain, stiffness, and loss of mobility), and dementia (loss of cognitive functioning). R2's Uniform Assessment Review dated July 26, 2024, identified no changes in the resident's condition from previous assessments. The assessment dated November 29, 2023, indicated R2's medications would be managed by staff including ordering, storing, setup, and administration. R2's Service Agreement dated November 10, 2023, indicated R2 received services including medication assistance four to six times daily. On July 30, 2024, at 8:02 a.m. unlicensed personnel (ULP)-B was observed to administer dorzalamide-timolol (for glaucoma) eye drops to R2 in his room. R2's dorzalamide-timolol eye drops were stored in R2's room on a bedside stand. On July 30, 2024, at 8:08 a.m. ULP-B was observed to apply pramoxine (anti-itch lotion) to R2's back, chest, and arms. R2's pramoxine was stored in R2's room on a bedside stand. On July 30, 2024, at 8:15 a.m. ULP-B was observed to administer brimonidine (for glaucoma) eye drops to R2 in his room. R2's brimonidine eye drops were stored in R2's room on a bedside stand. On July 30, 2024, at 8:15 a.m. immediately following eye drop administration ULP-B was asked about the storage of R2's eye drops and pramoxine lotion. ULP-B stated the eye drops and pramoxine had always been stored in his bedroom.	01880		

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01880	Continued From page 36 On July 31, 2024, at 4:03 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated all R2's medications should be kept in the locked medication cart and should not have been unsecured in R2's room. The licensee's Medication Administration and Supporting Processes policy dated reviewed/revised September 5, 2023, noted all medications would be stored in the locked community medication cart. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for two of two residents (R2, R5) and failed to ensure time sensitive medications were dated when open for two of two residents (R2, R5) with eye drops. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890		

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01890	Continued From page 37 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 On July 30, 2024, at 8:02 a.m. unlicensed personnel (ULP)-B was observed to administer dorzalamide-timolol (for glaucoma) eye drops to R2 in his room. R2's dorzalamide-timolol eye drops were stored in R2's room on a bedside stand. The eye drop lacked the original prescription label with R2's name, information regarding the directions for use, medication name, medication dosage, and the pharmacy in which it had been dispensed. In addition, the medication lacked a date when opened. On July 30, 2024, at 8:15 a.m. ULP-B was observed to administer brimonidine (for glaucoma) eye drops to R2 in his room. R2's brimonidine eye drops were stored in R2's room on a bedside stand. The eye drop lacked the original prescription label with R2's name, information regarding the directions for use, medication name, medication dosage, and the pharmacy in which it had been dispensed. In addition, the medication lacked a date when opened. On July 30, 2024, at 8:15 a.m. immediately following eye drop administration, ULP-B was	01890		

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01890	Continued From page 38 asked about the storage and prescription label of R2's eye drops. ULP-B stated there was not a label or open date on the eye drops, but knew they were R2's eye drops since they were in his room. ULP-B further stated she would follow the directions for use from the medication administration record (MAR) and stated the eye drops had always been stored in R2's bedroom. ULP-B indicated she was not aware there should be a open date on the eye drop bottles. R5 On July 30, 2024, at 9:15 a.m. ULP-G was observed to administer timolol maleate (for glaucoma) eye drops to R5 in her room. R5's timolol maleate eye drops were stored in R5's room in a locked cabinet. The eye drop lacked the original prescription label with R5's name, information regarding the directions for use, medication name, medication dosage, and the pharmacy in which it had been dispensed. In addition, the medication lacked an open date. ULP-G stated eye drops were supposed to be dated when opened and wasn't sure who had opened this bottle. On July 31, 2024, at 3:28 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated medications should have the original prescription label and R2's eye drops should be stored in the locked medication cart. In addition, CNS/LALD-A stated all eye drops need to be dated when opened and replaced after 30 days. The licensee's Medication Administration and Supporting Processes policy dated reviewed/revised September 5, 2023, noted all medications would be stored in their original labeled containers and be stored in the locked	01890		

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01890	Continued From page 39 community medication cart. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30517	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBER	75303 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 40 changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R2, R4). 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: During the entrance conference on July 29, 2024, at 10:47 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided treatment management services to residents, including compression stockings. R2 On July 30, 2024, at 7:58 a.m. unlicensed personnel (ULP)-H was observed to apply R2's thrombo-embolus deterrent (TED) stockings (compression stockings used to decrease fluid and improve circulation) to bilateral lower legs. ULP-H stated R2 had assistance with applying the TED stockings each morning and removal at bedtime. R2's diagnoses included cerebral infarction	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30517	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBER	75303 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 41 (stroke), bilateral cataract (clouded, blurred, or dim vision), glaucoma (high pressure in the eye leading to vision loss and blindness), osteoarthritis (form of arthritis affecting any joint and causes pain, stiffness, and loss of mobility), and dementia (loss of cognitive functioning). R2's Service Agreement dated November 10, 2023, indicated R2 received services including assistance with bathing, grooming, dressing (including assistance with application/removal of TED stockings), and medication assistance four to six times daily. R2 lacked prescriber orders for the TED stockings. R2's Tasks Completed record dated July 1, 2024, to July 29, 2024, lacked documentation of TED stocking assistance. R2's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On July 31, 2024, at 12:43 p.m. CNS/LALD-A stated R2's record lacked a treatment management plan to include all the required content as noted above. R4 R4's physician orders dated May 8, 2024, included an order for Lifestyle Comfort Socks (compression stockings), apply to lower extremity daily, remove before bed. R4's Tasks Completed form dated July 2024, indicated staff assisted R4 twice daily with	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30517	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBER	75303 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 42 compression stockings. On July 30, 2024, at 8:43 a.m. ULP-C was observed applying compression stockings to R4's lower legs. R4's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On July 31, 2024, at 2:34 p.m. CNS/LALD-A reviewed R4's record and stated R4's treatment plan did not include the above required content. The licensee's Treatment and Therapy Management Services policy dated March 18, 2024, indicated: 3. Documenting the plan, treatment or therapy activities: B. The documentation of the MAR/eMAR or TAR/eTAR will include the following components: iv. Procedures for notifying the registered nurse or appropriate licensed health professional when a problem arises with treatment and therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30517	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBER	75303 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 43 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 lacked documentation of treatments for one of three residents (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: On July 30, 2024, at 7:58 a.m. unlicensed personnel (ULP)-H was observed to apply R2's thrombo-embolus deterrent (TED) stockings (compression stockings used to decrease fluid and improve circulation) to bilateral lower legs. ULP-H stated R2 had assistance with applying the TED stockings each morning and removal at bedtime. R2's diagnoses included cerebral infarction (stroke), bilateral cataract (clouded, blurred, or dim vision), glaucoma (high pressure in the eye leading to vision loss and blindness),	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30517	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBER	75303 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 44 osteoarthritis (form of arthritis affecting any joint and causes pain, stiffness, and loss of mobility), and dementia (loss of cognitive functioning). R2's Service Agreement dated November 10, 2023, indicated R2 received services including assistance with bathing, grooming, dressing (including assistance with application/removal of TED stockings), and medication assistance four to six times daily. R2 lacked prescriber orders for the TED stockings. R2's Tasks Completed record dated July 1, 2024, to July 29, 2024, lacked documentation of TED stocking assistance. On July 31, 2024, at 12:43 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated ULP should be documenting the completion of all services and treatments provided. CNS/LALD-A stated R2's record lacked documentation of the TED stockings. The licensee's Treatment and Therapy Management Services policy dated reviewed/revised March 18, 2024, indicated the registered nurse will document the healthcare provider's order for treatment and therapy activities on the medication administration record (MAR) or the treatment administration record (TAR) and are subject to the same documentation requirements as medications/other orders as outlined in the assisted living policies and procedures. No further information was provided.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30517	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBER	75303 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 45 TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded treatment orders were maintained for two of three residents (R2, R4). 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: During the entrance conference on July 29, 2024, at 10:47 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided treatment management	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30517	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBER	75303 240TH STREET ALBERT LEA, MN 56007

(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
01970	Continued From page 46 services to their residents. R2 On July 30, 2024, at 7:58 a.m. unlicensed personnel (ULP)-H was observed to apply R2's thrombo-embolus deterrent (TED) stockings (compression stockings used to decrease fluid and improve circulation) to bilateral lower legs. ULP-H stated R2 had assistance with applying the TED stockings each morning and removal at bedtime. R2's diagnoses included cerebral infarction (stroke), bilateral cataract (clouded, blurred, or dim vision), glaucoma (high pressure in the eye leading to vision loss and blindness), osteoarthritis (form of arthritis affecting any joint and causes pain, stiffness, and loss of mobility), and dementia (loss of cognitive functioning). R2's Service Agreement dated November 10, 2023, indicated R2 received services including assistance with bathing, grooming, dressing (including assistance with application/removal of TED stockings), and medication assistance four to six times daily. R2 lacked prescriber orders for the TED stockings. R2's Tasks Completed record dated July 1, 2024, to July 29, 2024, lacked documentation of TED stocking assistance. On July 31, 2024, at 12:43 p.m. CNS/LALD-A stated R2's record lacked prescriber orders for the TED stockings. CNS/LALD-A stated there should be prescriber orders for treatments completed by staff.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30517	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBER	75303 240TH STREET ALBERT LEA, MN 56007

(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
01970	Continued From page 47 R4 On July 30, 2024, ULP-C was observed emptying R4's catheter bag. R4's diagnoses included neurogenic bladder (lack of bladder control due to brain, spinal cord, or nerve problems). R4's service plan signed May 26, 2022, indicted staff provided cueing and hands-on assist with AM and/or PM dressing/undressing, bathing, toileting, transfers, medication administration, housekeeping, laundry, and catheter care. R4's prescriber orders included: catheter 14-6 Fr-" (French) as directed. The order did not give specifics on frequency of catheter change. On July 31, 2024, at 2:34 p.m. CNS/LALD-A reviewed R4's prescriber orders and stated the catheter order did not include the frequency for changing the catheter. CNS/LALD-A further stated she changed R4's catheter every 28 days. The licensee's Treatment and Therapy Management Services policy dated reviewed/revised March 18, 2024, indicated the RN (registered nurse) is responsible for assuring that current, authorized healthcare provider orders for treatments and therapies administered by assisted living employees are kept and maintained in the resident medical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Environmental Health - FPLS

Rochester

Type: Full
Date: *07/30/24*
Time: 11:02:48
Report: 1038241094

Food and Beverage Establishment Inspection Report

Location:
Good Samaritan Society - Hidde
75303 240th St.
Albert Lea, MN56007
Freeborn County, 24

Establishment Info:
ID #: 0019284
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Good Samaritan Society-Albert

Phone #: 5073792737
ID #: 22998

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 187 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location:
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location:
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: 0 Degrees Fahrenheit - Location: Pancacks
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Ham Cubes
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Ice Cream
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Bread Loaf
Violation Issued: No

Type: Full
Date: *07/30/24*
Time: 11:02:48
Report: 1038241094
Good Samaritan Society - Hidde

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 145 Degrees Fahrenheit - Location: Muffins
Violation Issued: No

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

hstenset@good-sam.com

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1038241094 of 07/30/24.

Certified Food Protection Manager: Holly Stenseth

Certification Number: FM121914 Expires: 01/30/27

Signed: _____
Establishment Representative

Signed: _____
Rob Davis
Sanitarian 2
Rochester District Office
507-810-9902
rob.davis@state.mn.us

Minnesota Department of Health
Environmental Health - FPLS

Rochester

Type: Full
Date: *07/30/24*
Time: 11:33:09
Report: 1038241095

Food and Beverage Establishment Inspection Report

Location:
Good Samaritan Society - Alber
75303 240th Street
Albert Lea, MN56007
Freeborn County, 24

Establishment Info:
ID #: 0038278
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073792737
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 182 Degrees Fahrenheit
Location: Hotwater
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location:
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 190 Degrees Fahrenheit - Location: Chicken and Veg
Violation Issued: No

Process/Item: Hot Holding
Temperature: 181 Degrees Fahrenheit - Location: Ground Beef
Violation Issued: No

Process/Item: Hot Holding
Temperature: 203 Degrees Fahrenheit - Location: Soup
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Upright Cooler
Temperature: Degrees Fahrenheit - Location:
Violation Issued: No

Type: Full
Date: *07/30/24*
Time: 11:33:09
Report: 1038241095
Good Samaritan Society - Alber

Food and Beverage Establishment Inspection Report

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1038241095 of 07/30/24.

Certified Food Protection Manager: Holly Stenseth

Certification Number: FM121914 Expires: 01/30/27

Signed: _____
Establishment Representative

Signed: _____
Rob Davis
Sanitarian 2
Rochester District Office
507-810-9902
rob.davis@state.mn.us