DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 11, 2025

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

RE: CCN: 245568
Cycle Start Date: December 27, 2024

Dear Administrator:

On February 4, 2025, we notified you a remedy was imposed. On March 9, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 14, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 27, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 4, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 27, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 14, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

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March 11, 2025

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

Re: Reinspection Results
Event ID: PSYH12

Dear Administrator:

On March 9, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 27, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 4, 2025

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

RE: CCN: 245568
Cycle Start Date: December 27, 2024

Dear Administrator:

On January 14, 2025, we informed you that we may impose enforcement remedies.

On January 14, 2025, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedies listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 27, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 27, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 27, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 27, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Mary Jane Brown will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 27, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E"tag), i.e., the plan of correction should be directed to:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 27, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services

determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered

February 4, 2025

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

Re: State Nursing Home Licensing Orders
Event ID: PSYH11

Dear Administrator:

The above facility was surveyed on January 12, 2025 through January 14, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE 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) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/12/25 through 1/14/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55681420C (MN106386). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:	F 576		2/14/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	01/14/2025

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GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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F 576	Continued From page 1 (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview the facility failed to ensure resident mail was delivered consistently on Saturdays for 2 of 2 residents (R18, and R25) who voiced concerns with mail delivery. This deficient practice had the potential to affect all 37 residents residing in the facility. Findings include: R25's 12/11/24, Significant Change in Condition Minimum Data Set (MDS) assessment identified	F 576	1. R18 and R25 and all other residents will have their mail delivered to them every Saturday by an activities staff member or designee. 2. All residents residing in the facility have the potential to be affected by this deficient practice. 3. To ensure systemic changes are sustained, we will do staff training on resident's rights to have access to their mail and have it delivered on time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE 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) COMPLETION DATE
F 576	Continued From page 2 R25's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 15. Interview on 1/13/25 at 1:10 p.m., during the Resident Council meeting, R25 identified he did not always get mail on Saturdays because there was only one activity staff who worked on Saturdays so there were times when his mail was not delivered until Sunday or Monday. R18's 12/10/24, Significant Change in Condition MDS assessment identified R18's cognition was intact with a BIMS score of 15. Interview on 1/14/25 at 7:34 a.m., with R18 identified she did not receive mail every Saturday and it was a "hit or miss" as the activity staff were only here long enough to help feed residents at noon and then they left. Interview on 1/13/25 at 1:26 p.m., with social worker designee/activity director identified the mail was brought to the front desk and activity staff delivered the mail Monday through Saturday and there was no mail delivery on Sundays. She reported there was always activity staff working on Saturday however, if the mail came after the activity staff left for the day residents did not receive their mail until Monday morning. She identified that did not happen very often. She revealed the maintenance director brought the mail to the reception desk and placed it in a white basket daily and the activity staff delivered it. She confirmed that the maintenance director was the only staff member who picked the mail up out of the actual mailbox. Interview on 1/13/25 at 1:30 p.m., with the maintenance director identified he picked the mail	F 576	Training was done 2/9-2/10/2025. Activities staff members or designee will be available to deliver the mail on Saturdays. The facility has adjusted the schedules of the activities staff members so that one will be available to every Saturday to deliver mail to the residents. 4. To ensure compliance is maintained, audits will be conducted to ensure mail was delivered on Saturdays, weekly x4 and monthly x3 and randomly thereafter. Results will be brought to the QAPI committee for further recommendations monthly. 5. Date of completion is 2/14/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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F 576	Continued From page 3 up out of the mailbox located outside of the facility Monday through Friday and dropped it off at the receptionist desk. Interview on 1/13/25 at 1:40 p.m., with the administrator in training (AIT) identified if the mail was delivered on Saturday by the post office that anyone from the facility could pick it up from the mailbox and deliver it to the residents. She reported her expectation was that if the post office delivered mail on Saturday, then the residents would receive their mail on Saturday. Interview on 1/13/25 at 1:44 p.m., with social worker designee/activity director revealed that mail at times was delivered after 5:00 p.m., on Saturdays and that was the reason the residents not receive their mail until Monday. A mail service policy was requested but not provided. A policy for Resident Mail and Parcel Services for Senior Living and Affordable Housing policy was provided but did not include long term care.	F 576		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 657	Continued From page 4 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R11) care plan was revised to show meal preferences. Findings include: R11's 12/16/24, significant change Minimum Data Set (MDS) assessment identified his cognition was moderately impaired, he required limited assistance with transfers and activities of daily living (ADL's). R11 had diagnosis of dementia, diabetes, Parkinson's disease, and anxiety disorder. Interview on 1/12/25 at 11:42 a.m., with family member (FM)-A identified she has told staff several times that he does not like fish or turkey, but they continue to serve it to him. Review of R11's nutritional assessment identified	F 657	1. R11's care plan was updated on 1/29/2025 to include his preference not to be served fish and other food he dislikes. 2. All residents were interviewed if appropriate, to ensure that they were not being served foods that they did not enjoy, and care plans were updated as appropriate. The dietary manager completed reviews of all residents food preferences and updated their care plans accordingly; this review was completed on 2/7/25. 3. To ensure systemic change is sustained, dietary and nursing staff will be provided with education on the importance of food preferences and making sure those are updated on resident care plans. 4. To ensure compliance is maintained, audits will be done on resident food preferences and food satisfaction and reviewed at care conferences, weekly x4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE 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) COMPLETION DATE
F 657	Continued From page 5 multiple foods that R11 did not like but made no mention of his request not to be served fish. R11's current care plan identified a nutritional focus with a goal for R11 to express that his nutritional needs are being met and that he feels supported. The staff were to discuss coping behaviors related to self-image concerns, he prefers to dine in his room, uses adaptive equipment and staff should monitor and report any signs of difficulty chewing or swallowing. The care plan made no mention of R11's food likes or dislikes. Observation and interview on 1/12/25 at 5:50 p.m., R11 was eating supper in his room, he identified he did not like fish and pointed to his sandwich. He said the sandwich was tuna fish and "tasted like slop". Interview on 1/12/25 at 6:01 p.m., with nursing assistant (NA)-C identified residents get a menu slip each morning at breakfast to fill out their meal choices for the day. At the bottom of the slip, it lists dietary preferences and on the back, it lists the any-time menu options. Interview on 1/12/25, at 6:10 p.m., with cook-A identified the nursing assistants bring the menu slips to the kitchen and the cook reviews them as they are preparing the meal trays. Cook-A retrieved R11's menu slip for supper meal and revealed it was blank. Cook-A identified that R11's slip is often blank when it is returned to the kitchen. Observation of R11's menu slip identified the any-time menu items were not listed on his slip. R11's dietary preferences were listed at the bottom, however, there was no mention of his dislike of fish.	F 657	for three months until 100% compliance is achieved. Results will be brought to QAPI committee. 5. Date of completion is 2/14/2025.	

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F 657	Continued From page 6 R11's current treatment record identified a physician order for nursing to check with resident about meal choice, they were to be specific about each option on the menu and what foods he would like staff to cut up. They were to communicate R11's choices to the nursing assistant that is gathering menu slips so that it can be passed on to the kitchen due to his swallowing issues. Interview on 1/13/25 at 8:23 a.m., with the dietary manager (DM)-F identified he asks about preferences at the care conference meeting. He lists the preferences on each resident's diet card. The diet cart is a laminated card used in the kitchen while preparing meal trays. He revealed that R11's dietary card has "NO FISH" noted on the card, he agreed that R11 did receive fish at supper during the evening meal on 1/12/25. DM-F also identified that he was not aware that R11's menu slips were not being filled out prior to being returned to the kitchen. Observation of R11's laminated dietary card had noted NO FISH noted on the bottom left corner. A policy was requested but not provided by the end of the survey.	F 657		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law	F 755		2/14/25

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F 755	Continued From page 7 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed administer 1 of 1 medication (levothyroxine) according to labeled instructions for 1 of 25 medication administration observations. Findings include: Observation and interview on 1/13/25 at 8:29 a.m., with licensed practical nurse (LPN)-A as she obtained R 92's Levothyroxine 150 micrograms (mcg) from the medication cart. The order on the	F 755	1. R92's provider was contacted to verify the order for the drug dose and frequency. The order was entered correctly into the Medication Administration Records (MARs). 2. All residents have the potential to be affected by this deficient practice. 3. To ensure systemic changes will be made, the facility will provide education to all nurses on the process of using change stickers and appropriately updating orders in the MAR. Nurses were provided with	

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F 755	Continued From page 8 electronic medical record (MAR) identified: (Levothyroxine) Synthroid Oral tablet 150 mcg 1 tablet by mouth (PO) one time a day (QD) before breakfast. LPN-A removed the card containing the medication, checked it against the MAR and punched out a pill into the medication cup. The label on the bubble pack directed take 1 tablet PO QD before breakfast. Do not take with Iron, Aluminum, Magnesium, or Calcium containing products. LPN-A returned the card to the medication cart and continued dispensing R92's medications into the same medication cup. R92's medications in the same med cup included: Calcium 600 mg/D3 (Calcium supplement with vitamin D) 2 tablets PO Q AM, and Ferrous Sulfate (iron supplement) 325 milligrams (mg) PO Q AM. LPN-A took the cup containing the medications to R92's room and administered the cup of medications. Upon returning to the cart to document administration of the medications, LPN-A reviewed the levothyroxine. LPN-A reported she had not noted the instructions printed on the Levothyroxine label to not administer with Iron or calcium. The instructions had also not been included in the MAR. She reported she had not noticed the additional instructions printed on the Levothyroxine label and had always administered all of R92's morning medications at the same time. The instructions should have been included in the MAR and the Calcium/vitamin D and Ferrous Sulfate should have been scheduled at a different time. Interview on 1/13/25 at 8:40 a.m., with LPN-A identified she had checked the medication card against the MAR and determined it was the correct medication, but she had not noted the additional printed instructions. LPN-A would give the medication card to the charge nurse to be	F 755	education 2/11/2025 and 2/13/2025. Nursing leadership will audit medication carts and verify all medications with change stickers have orders entered correctly into the MAR. This was completed on 2/10/2025. 4. Audit will be completed weekly x4 and monthly x3 and randomly thereafter using an audit tool to ensure that corrective actions are achieved and sustained and that the process is being followed. 5. Date of completion: 2/14/2025	

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F 755	Continued From page 9 corrected in the MAR to ensure the error did not continue. Interview on 1/13/25 at 8:50 a.m., with the interim director of nursing (IDON) identified staff passing medications were expected to be reading and comparing medication cards against the MAR and if there was a discrepancy then checking with the charge nurse, and pharmacy for direction. She reported the Levothyroxine had likely been administered with the Calcium and Ferrous Sulfate for the past three days as they were documented as administered at the same time on the MAR. She reported she would have expected staff persons preparing the medication to have caught the label precaution. Review of the May 21, 2024: Medication: Administration Including Scheduling and Medications Aides policy identified the "Six Rights" of medication administration were to be followed by all staff administering medications to residents. Scheduling of medication administration was to be scheduled to avoid potential significant medication interactions identified as with food, or other medications. The administration procedure identified to review the MAR for medications that were due for administration, follow the "Six Rights" 1.) Right medication; 2.) right dose; 3) right resident; 4.) right route; 5.) right time; 6.) right documentation. Perform three checks: Read the label on the container/card and compare with the MAR 1.) when removing from the cart; 2.) placing the medication in the cup; 3.) just before	F 755		

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F 755	Continued From page 10 administering the medication.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		2/14/25

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F 758	Continued From page 11 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to complete an Abnormal Involuntary Movement Scale (AIMS) for 1 of 1 resident (R12) reviewed for unnecessary medications per facility policy and procedure. Findings include: R12 was admitted September 2023 and had a diagnosis of dementia, depression, and heart failure. He had taken Seroquel (treats schizophrenia, bipolar disorder, and manic disorder) 25 milligrams (mg) at bedtime for dementia with a start date of 1/19/24 and sertraline (treats depression) 100 mg daily for depression with a start date of 9/16/23. R12's, 12/11/24 Significant change Minimum Data Set (MDS) identified he was cognitively impaired had little interest or pleasure in doing things and had felt down, depressed, or hopeless never to 1 day. R12 had taken antipsychotics and antidepressants on a scheduled basis. R12's, medical record identified an initial AIMS	F 758	1. AIMS assessment was completed for R12 on 2/7/2025. 2. Any residents receiving an antipsychotic have the potential to be affected by this deficient practice. The medical records of all residents who receive antipsychotics was reviewed to ensure they have an up to date AIMS assessment completed. This was completed on 2/10/2025. 3. To ensure systemic change is made and that the deficient practice does not reoccur, all nurses were educated on the AIMS assessment on 2/10/2025. 4. To ensure compliance is maintained, audits of residents receiving antipsychotics will be done to ensure AIMS assessment are completed timely. Audits will occur weekly x4 and monthly x3 and the results will be brought to the QAPI committee for further recommendations. 5. Date of completion is 2/14/2025.	

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F 758	Continued From page 12 (test used to assess abnormal movements in people with on anti-psychotic or psychotropic medication) in September 2023. The medical record had lacked evidence of a bi-annual or annual AIMS assessment thereafter. R12's current, undated care plan identified R12 had used psychotropic medication related to dementia and depression. Interventions were for staff to consult with pharmacy, health care provider to consider dosage reduction, discuss with health care provider for ongoing need of use of medications, educate resident/family about risks, benefits, side effects and toxic symptoms of medication, and would monitor target behaviors such as refusal of cares and lack of self-awareness related to safety. During interview on 1/13/25 at 4:34 p.m., with the interim director of nursing (IDON) identified she expected staff to perform updated AIMS assessment for residents taking psychotropic medication according to the facility policy, as indicated. Review of December 2024 Psychotropic Medications- Rehab/Skilled policy identified staff were to complete an initial antipsychotic medication assessment and an AIMS assessment to screen for signs or symptoms of potential Tardive Dyskinesia (abnormal movements caused by psychotropic medication). In addition, staff were to complete the AIMS assessment every 6 months. If a change was identified in a resident from the previous AIMS assessment the registered nurse would inform the primary care physician and family/legal guardian representative and would document the notification in the resident medical record.	F 758		

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F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 5 of 5 residents (R4, R15, R18, R32 and R91's) discontinued controlled narcotic medications were not stored with in-use medications in 2 of 2 medication carts. Findings include: Observation and Medication Administration	F 761	1. Discontinued controlled narcotic medications for R4, R15, R18, R32, R91, were separated from the active narcotics and placed in a separate double locked drawer in the medication room until such time they can be destroyed from limited access. 2. All other residents receiving narcotic medications have the potential to be affected.	2/14/25

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F 761	Continued From page 14 Record (MAR) on 1/12/25 at 6:03 p.m., with registered nurse (RN)-D and licensed practical nurse (LPN)-B during a controlled narcotic medication count of 2 of 2 medication carts identified: 1) R4 had 1 box of 5 Fentanyl 25 mcg patches stored in the East medication cart, which RN-D identified had been sent in error by the pharmacy and received by the facility on 1/8/25 or 1/9/25. The pharmacy had been notified on 1/9/25 when the error had been discovered and confirmed none of the incorrect patches had been administered. She reported the patches had been left in the medication cart until they could be destroyed. 2) R18 had 2 unopened blister packs each containing 30 tablets of Lorazepam 0.5 milligrams (MG) which RN-D confirmed were discontinued on 1/8/25. 3) R19's medical record identified he was deceased on 1/11/25 and his medications remained in the in-use narcotic box identified as: Morphine Sulfate 100 mg/5 milliliters (ml) unopened 15 ml bottle, 1 opened bottle of Morphine Sulfate 100 mg/5 ml with 8.75 ml remaining in the bottle, 2 blister packs of Lorazepam 0.5 mg tablets 1 blister package containing 1 tablet and 1 pack containing 30 tablets. The medical record identified the Lorazepam had been discontinued on 1/8/25. 4) R32 had 2 unopened blister packs of Lorazepam 0.5 mg tablets with each blister package containing 30 tablets. The medical record identified this medication was discontinued on 1/8/25. 5) R91 had 2 blister packs of Oxycodone HCl 5 mg tablets 1 blister pack contained 12 tablets, and 1 pack contained 30 tablets. The record identified the medication had been discontinued	F 761	3. To ensure systemic changes are made, all licensed nursing staff were educated on the process of separating discontinued narcotics from active narcotics on 1/16/25, 2/11/25 and 2/13/2025. Discontinued narcotics will be destroyed at least weekly by nursing leadership or designee. An audit of the medication carts was completed to ensure that all discontinued medications were removed and placed in the double locked drawer in the medication room until such time as they can be destroyed for limited access. 4. To ensure compliance is maintained, audits will be conducted to ensure discontinued controlled narcotic medications from active narcotic medications. Audits will be done weekly x4 and monthly x3. Results will be brought to the QAPI committee for further recommendations. 5. Date of completion is 2/14/2025	

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F 761	Continued From page 15 on 1/9/25. Interview on 1/12/25 at 6:25 p.m. with RN-D and LPN-B identified when a controlled medication was changed or discontinued the medication continued to be counted with each narcotic count and stored in the narcotic boxes located on the medication carts, until 2 licensed staff had time to destroy them. Both nurses reported they were not aware discontinued medication was not to be stored with in-use medications. Interview on 1/12/25 at 6:33 p.m. with the interim director of nursing (DON) identified she was not aware discontinued controlled medications were being stored with in-use medications. When a controlled medication was discontinued or changed resulting in the need for destruction, it should be removed from the in-use medications and stored in a separate secured location until destroyed. The medications would still need to be counted with each narcotic count until destruction with appropriate documentation was completed. Interview on 1/14/25 at 4:25 p.m. with the consultant pharmacist confirmed discontinued controlled medications should not be commingled with in-use medications due to the potential for error or diversion. She was not aware this was occurring and would investigate the situation further with her next visit to the facility on 1/15/25. Review of the May 21, 2024, Policy Medication Administration failed to contain documentation on controlled medication storage, and no additional policies were provided by the end of the survey period.	F 761		
F 880 SS=D	Infection Prevention & Control	F 880		2/14/25

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F 880	Continued From page 16 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 17 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow appropriate infection control practices for 1 of 2 residents (R2) indwelling catheter. Findings include: R2's, 12/11/24 Significant Change Minimum Data Set (MDS) assessment, identified she was cognitively intact and had a diagnosis of	F 880	1. R2 and staff were provided with education on infection prevention practices related to catheters use. R2 was provided a stainless steel stand with a cross bar on the top to hang her catheter drainage bag from. This will ensure that it hangs below the bladder and above the floor. Resident was educated on the placement of the bag and the reason. 2. All residents who have a catheter are at	

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	245568	A. BUILDING _____ B. WING _____	01/14/2025

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F 880	Continued From page 18 neurogenic bladder (bladder problems related to injury or disease), which required a urinary draining bag (tube that collects urine from the bladder). R2's, current, undated care plan identified interventions for staff to monitor, record, and report to the health care provider signs and symptoms of urinary tract infection (UTI), such as pain, burning, blood-tinged, foul-smelling urine, fever, altered mental status, change in behaviors, and change in eating patterns. During initial interview and observation on 1/12/25 at 11:46 a.m., with registered nurse (RN)-A and R2 identified R2 was seated in her recliner and the urinary drainage bag was hung from the trash can over a gray basin that was placed on the floor next to R2's recliner. R2 stated she and nursing staff hung her urinary drainage bag from the trash can to keep the catheter tubing below her bladder. Observation on 1/12/25 at 1:13 p.m., as the interim director of nursing (IDON) wheeled R2 to her room and assisted R2 with transfer to her recliner. When the IDON exited the room, R2's urinary drainage bag was hung from the trash can. Interview on 1/13/25 at 10:40 a.m., with nursing assistant (NA)-A reported R2 transferred her urinary drainage bag from her walker and hung it from the trash can. She informed R2 it was not a good idea for the urinary drainage bag to be hung from the trash can and offered to place the urinary drainage bag to another location. During interview on 1/13/25 at 10:43 a.m., with	F 880	risk for this deficient practice. 3. To ensure systemic change is made, all nursing staff will be provided with education on infection control policies and procedures. This education was provided 2/13/2025. 4. To ensure systemic change is maintained, audits will be conducted weekly x4 and monthly x3 and brought monthly to the committee. 5. 2/13/2025	

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F 880	Continued From page 19 registered nurse (RN)-A she reported R2 was independent with her care needs and would need reinforcement and education of properly securing her urinary drainage bag to prevent contamination. Observation and interview on 1/13/25 at 4:14 p.m., with RN-B in attendance, noted R2's catheter bag was again hung from the trash can, upon entering R2's room. She confirmed it was not an acceptable infection control practice and would need to re-educate R2 of appropriate techniques to position her urinary drainage bag when in use. Observation and interview on 1/13/25 at 4:16 p.m., trained medication aide (TMA)-A in attendance, noted R2's urinary drainage bag was again hung from the trash can. TMA-A stated R2's urinary drainage bag that was hung from the trash can was not the appropriate place for the catheter bag and stated R2 had limited options on where she could hang her urinary drainage bag when seated in her recliner. During interview on 1/13/25 at 4:34 p.m., with the IDON she stated nursing staff and R2 would need further education on infection control practices related to urinary drainage bag placement to prevent complications and reduce infection control risks. Review of July 2024 Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen-AL, R/S & LTC policy identified the facility staff would maintain and properly secure catheters. Secondly, closed connection systems, such as, indwelling catheters that were found to be contaminated by inappropriate infection	F 880		

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F 880	Continued From page 20 control practices were to be replaced, immediately. In addition, the facility staff would educate and document residents and/or family of the risk and benefits of indwelling catheters use.	F 880		
F 949 SS=D	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 8 staff received newly hired staff nursing assistant (NA-D) received initial training on Alzheimer's disease or related disorders, assistance with activities of daily living (ADL), problem solving with challenging behaviors, and communication skills. This had the potential to affect all the residents in the facility. Findings include: Review of the employee file for nursing assistant (NA)-D had a hire date of 10/29/24. Interview on 1/13/25 at 4:41 p.m., with interim director of nursing would expect Alzheimer/Dementia training to be completed for all staff who are taking care of vulnerable adults at the facility. Review of August 2024 Facility Assessment identified the facility would train staff on Dementia and behavioral health during general orientation.	F 949	1. Upon research, NA-D was found to have completed the training on Alzheimer's disease, ADL and problem solving with challenging behaviors on 10/29/2024. The record was confirmed with our continuing education department. 2. No staff members were considered to be deficient in this practice upon further research. 3. To ensure systemic changes are sustained, we did an audit of all training records of all current employees and new hires all necessary trainings are completed. Education will be given to the leadership team to ensure their new hires have completed all required trainings. 4. To ensure compliance is maintained, audits of new staff members training will be done, weekly x3 and monthly x3. 5. Date of completion is 2/14/2025.	2/14/25

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F 949	Continued From page 21 In addition, the facility would provide annual staff in-services pertaining to Federal and State requirements related to continuity of care and resident safety. Copy of NA-D training policy was requested and not provided during survey.	F 949		

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E 000	Initial Comments On 1/12/25 through 1/14/25 a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/13/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/14/2023, At the time of this survey, Good Samaritan Society, Mary Jane Brown was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building 01 of Good Samaritan Society Mary J. Brown was constructed as follows: The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1965, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1987, is one-story, has no basement, is fully fire sprinkler	K 000		

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K 000	Continued From page 2 protected and is of Type II(000) construction; The 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The 4th Addition was constructed in 2011, is a new main entrance, offices, conference room and beauty shop, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II (111) construction. The facility has smoke detection at smoke barrier doors and in spaces open to the corridor, which are monitored for automatic fire department notification. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.The facility has a capacity of 51 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 353		2/14/25

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K 353	Continued From page 3 b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 13, Standard for the Installation of Sprinkler Systems, section 8.5.6, These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 01/14/2025 between 10:00 AM and 12:30 PM, it was revealed by observation that there was storage exceeding 18 inches through out the building not allowing sprinkler to perform properly if activated. An interview with Administrator and Maintenance Supervisor verified these deficient findings at the time of discovery.	K 353	1. All areas where storage exceeded 18 inches in the facility have been cleared to ensure sprinklers are not obstructed on 1/15/2025. Built in activities storage was cut off on 2/11/2025 to ensure sprinklers are not obstructed. 2. All residents in the facility have the potential to be affected by this deficient practice. 3. To ensure systemic change is sustained, maintenance director/designee put up signs that have been placed in all storage units indicating the 18-inch clearance needed in the effected sprinkler areas. All staff received training on fire safety and the importance of maintaining proper clearance and education in ensuring that no storage exceeds the limit. Education was completed 2/13/2025. 4. To ensure compliance is maintained, audit will be done twice a week for two weeks and 100% compliance is achieved. Then once a week for two weeks and 100% compliance is achieved. Maintenance director or designee will perform inspections of storage areas to make sure no items are stored within clearance to ensure compliance. 5. Date of completion is 2/14/2025	

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K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		2/14/25

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K 363	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a isolated impact on the residents within the facility. Findings include: 1. On 01/14/2025 between 10:00 AM and 12:30 PM, it was revealed by observation that the door to resident room 115 would not latch. An interview with the Administrator and the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 363	1. Resident room 115's door was identified and has been repaired. 2. All residents residing in the facility have the potential to be affected by this deficient practice. An audit was completed of all resident room doors. Eleven additional doors were repaired. 3. All staff were educated in fire safety prevention. Education was completed 2/13/2025. 4. Resident room doors were added to the monthly checklist to identify any repairs needed. The maintenance director will audit room doors monthly for three months and until 100% compliance is achieved. 5. Date of completion is 2/14/2025.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct	K 712	1. The missing fire drill was performed 2/13/2025.	2/14/25

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K 712	Continued From page 6 fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1.On 01/14/2025 between 10:00 AM and 12:30 PM, it was revealed by a review of available documentation that the times that the facility conducted the first shift fire drills were not varied. 2.On 1/14/2025 between 10:00 AM and 12:30 PM, it was revealed by a review of available documentation that the fire alarms were not being tested the following day after night shift fire drills. An interview with the Administrator and the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 712	2. The deficient practice had the potential to affect all residents. The maintenance director performed a makeup fire drill on 2/13/2025. 3. To ensure systemic change is sustained, the fire drill schedule was updated to ensure drills are conducted under varied times and that fire alarms are tested the following morning after a night shift fire drill. Log will be maintained to track all fire drills and alarm tests to ensure compliance. The maintenance director and designee received education on the importance of fire safety and conducting fire drills under varied times. Education was completed 2/13/2025. 4. To ensure compliance is maintained, maintenance director/designee will audit fire drill logs monthly for three months until 100% compliance is achieved, and results will be reported at QAPI until 100% compliance is achieved. 5. Date of completion is 2/14/2025	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if	K 923		2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE** **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) COMPLETION DATE
K 923	Continued From page 7 sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/14/2025 between 10:00 AM and 12:30 PM, it was revealed by observation that the Med Gas (O2) Storage Room contained storage of	K 923	1. All combustible materials from medical gas storage rooms throughout the facility were removed on 1/17/2025 to comply with safety regulations. Inventory of materials has been done to ensure proper segregation of medical gasses from hazardous/flammable materials. 2. All residents residing in the facility have the potential to be affected by this deficient practice. All medical gas storage areas in the facility were inspected and any combustible materials found were removed by MDS nurse on 1/17/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE** **LUVERNE, MN 56156**

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K 923	Continued From page 8 combustible materials. An interview with the Administrator and Maintenance Supervisor verified this deficient finding at the time of discovery.	K 923	3. To ensure systemic change is sustained, storage rooms will be regularly inspected by maintenance director or designee to ensure no combustible materials are stored in that area. Signs have been placed in medical gas storage areas indicating proper medical gas storage management. All nursing staff and maintenance director/designee received education on the proper handling and storage of medical gases and flammable materials on 2/13/2025. 4. To ensure compliance is maintained, audits will be conducted by maintenance director and nurse leaders on storage areas weekly x2 for three months until 100% compliance is achieved. Report and findings will be brought to monthly QAPI committee. 5. Date of completion is 2/14/2025.	