DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 14, 2026

Administrator
Good Samaritan Society - Stillwater
1119 OWENS STREET NORTH
STILLWATER, MN 55082

RE: CCN: 245207

Cycle Start Date: December 10, 2025

Dear Administrator:

On January 7, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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January 14, 2026

Administrator
Good Samaritan Society - Stillwater
1119 OWENS STREET NORTH
STILLWATER, MN 55082

Re: Reinspection Results
Event ID: 1DA2F6-H2

Dear Administrator:

On January 7, 2026 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 10, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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December 10, 2025

Administrator
Good Samaritan Society - Stillwater

1119 OWENS STREET NORTH
STILLWATER, MN 55082

RE: CCN:245207
Cycle Start Date: December 10, 2025

Dear Administrator:

On December 10, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 10, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 10, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Administrator
Good Samaritan Society - Stillwater
1119 OWENS STREET NORTH
STILLWATER, MN 55082

Re: State Nursing Home Licensing Orders
Event ID: 1DA2F6-H1

Dear Administrator:

The above facility survey was completed on December 10, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Stillwater	**1119 OWENS STREET NORTH , STILLWATER, Minnesota, 55082**

(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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 10/29/25 - 10/30/25, an abbreviated complaint survey was conducted at your facility by surveyor from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following correction order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		12/16/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/10/2025**

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20000	Continued from page 1 The following complaint was reviewed:H52076582C (2652923) with a licensing order issued at 1545. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An	21545	Corrected	12/17/2025

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21545	Continued from page 2 incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure liquid morphine (opioid analgesic used to treat severe pain) was administered per physician orders for 1 of 1 resident (R1) who was administered ten times the ordered dose. Findings include: R1's quarterly Minimum Data Set (MDS) dated 8/19/25, indicated diagnosis of anemia, heart failure, diabetes mellitus, and seizure disorder. The MDS indicated she was moderate cognitively intact and required assistance with activities of daily living. The MDS indicated R1 received scheduled pain medication and had a condition or chronic disease that may result in life expectancy of less than 6 months and received hospice care. R1's Care Plan dated 10/13/25, indicated R1 had acute and chronic pain/discomfort related to history of cerebral vascular accident and weakness. The care plan indicated nursing to evaluate the effectiveness of pain interventions after administration of pain medication, satisfaction with results, impact on functional ability and impact on cognition. The Care Plan further indicated R1 had terminal prognosis related to acute on chronic heart failure and was on hospice. R1's Physicians Orders dated 10/1025 indicated morphine sulfate (concentrate) oral solution 20 milligrams (mg)/ milliliters (ml), give 0.75 ml one hour as needed for pain or dyspnea. R1's Medication Administration Record (MAR) indicated on 10/10/25 R1 received 0.75 ml on 6:53 a.m. and 9:02 a.m. The order was increased to give 20mg/ml, give 1 ml as needed every one hour as needed for pain or dyspnea on 10/10/25, the MAR indicated this dose was never given. A Hospice Client -New Orders dated 10/10/25, ordered from hospice physician (over the phone) and transcribed by hospice nurse, registered nurse (HRN)-A to discontinue morphine 20mg/ml to give 1ml every one hour	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/10/2025**

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21545	Continued from page 3 as needed (PRN). Begin morphine 20 mg(ml) give 15mg/7.5 ml oral/ sublingual every four hours for restlessness, and morphine 20 mg/ml may have 15 mg/7.5 ml every one hour for dyspnea or pain. (This went from the 0.75 ml dose R1 received to 7.5 ml which is ten times the dosage and transcribed incorrectly) The MAR indicated on 10/10/25 at 12:00 p.m., R1 received 7.5 ml of Morphine Sulfate concentrate for pain level of four. R1's MAR indicated she received Narcan 4 mg, also known as Naloxone (naloxone, a front-line defense in the nation's overdose crisis. Naloxone is a life-saving drug that, when sprayed into the nose or injected, quickly reverses the powerful effects of opioids during an overdose) on 10/10/25, at 9:18 p.m. and 10:53 p.m. with all doses listed as effective. A Provider follow up Note Progress Note dated 10/10/25, indicated R1 presented with hypertensive heart disease with chronic diastolic heart failure, hospice care, hemiparesis, and expressive aphasia. The note indicated patient was seen multiple times today this afternoon and evening dule to medication error with administration of morphine sulfate. Extensive discussion with patient's daughter, granddaughter. Spoke with hospice staff and hospice medical director. Narcan 4 mg was administered 4:00 p.m. and as of 8:30 pm. patient has not required another dose. Respiration rate (RR) remaining above 8 and around 8:00 p.m. was 18. Director of nursing and nursing staff are monitoring patient closely and checking RR every 15-30 minutes. At 8:40 p.m. patient was seen and had been repositioned. Breathing was shallower, rate appeared to be decreasing. Discussed with DON and we opted to give another dose of Narcan 4mg. Once given patients breathing appeared to improve, she was yawning and moving her mouth more and seemed less sedated. Nursing will be monitoring closely through the night. Again, extensive discussion with family at bedside, questions addressed, concerns addressed. Daughter plans on leaving to go home around 9:00 p.m. Was informed by text message that a third dose of Narcan was given just before 10:00 p.m. due changes in respirations. A requested MAR to the DON on 11/06/25, was not received until 11/18/25, by the facility administrator which indicated the dose that was given at 10:53 p.m. was in error and that was actually given at 4:50 p.m. and received it at 9:18 p.m. (which does not match what the NP indicated in her notes R1 received three doses of Narcan) Interview on 10/29/25 at 1:16 p.m., the director of nursing (DON) stated on 10/09/25, R1 was up in her	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/10/2025**

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21545	Continued from page 4 wheelchair seemed perfectly fine normally arguing with me not wanting to go to bed then on 10/10/25, in the morning when I came in around 10:00 a.m. the nursing staff told me she had a stroke. The DON stated the hospice nurse came in and evaluated R1 and felt she had cardiac or CVA (cerebral vascular accident) and increased her morphine. The hospice nurse made a medication error and instead of transcribing morphine .75 ml to be given she transcribed 7.5 ml and the at 12:00 p.m., RN-A administered morphine sulfate 7.5 ml. from an existing bottle of morphine R1 had. The DON stated the evening nurse licensed practical nurse (LPN)-A noticed the medication error when the new morphine medication arrived with the prescription label that indicated to give .75ml instead of 7.5 ml. LPN-A then informed hospice and orders for Narcan were given and she corrected the transcription in the MAR to read to give 7.5 ml. The DON stated the first dose of Narcan was given after they repositioned R1 and she had a few episodes of apnea, and they were not sure if it was from the repositioning or the medication error, so they administered the Narcan and gave the other doses prophylactically. The DON stated she discussed with RN-B how they could learn from this and started education right away and explained how this was a transcription error and how we need to slow down and asses and question if this is an appropriate order especially if someone is taking an opioid. During interview on 10/30/25 at 10:27 a.m., hospice medical director stated she was informed the morning of 10/10/25 R1 was having stroke-like symptoms, and the hospice nurse increased her morphine due to signs of being uncomfortable, increased breathing and restlessness. Which were signs of pain and labored breathing. The medical director then stated she was informed the hospice nurse transcribed the order with the correct mg but the incorrect ml which was 7.5 and the facility nurse gave the morphine at 7.5 ml. The medical director stated R1 was not receiving much morphine and a dose like that could have killed her although the dose would be out of her system by 8 hours which in her case it did. During interview on 10/30/25 at 12:34 p.m., RN-B stated R1 was in distress the morning of 10/10/25, and the hospice nurse arrived and placed new orders to increase her morphine concentrate to 7.5 ml. RN-B stated R1 already had morphine on hand and at 12:00 p.m. she used what she had and in order to dose that much she had to use eight syringes which she thought was a lot but never said anything to anyone and administered the medication to R1. Later that day around 3:00 p.m. she received a phone call from the evening nurse LPN-A who	21545		

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21545	Continued from page 5 informed her the new morphine medication arrived with the label reading .75 ml not 7.5 ml and realized it was a medication error. RN-B stated she immediately informed the DON and the Nurse Practitioner (NP) that were present in the building and Narcan was ordered as needed and 15-minute respiratory checks for R1. RN-B stated she did not recall receiving any re-education on the medication error from the DON. During interview on 10/30/25 at 1:05 p.m., LPN-B stated she worked on 10/11/25 and 10/12/25 and stated R1 stated in bed all weekend and she was unresponsive she did not open her eyes. LPN-B stated she knew not to ever give anyone more the 2ml of morphine and couldn't believe the order went through and fell through the cracks and was not caught until after R1 received the dosage. LPN-B stated they double check new orders with new admissions but not with orders that come through from hospice. During interview on 10/30/25 at 3:15 p.m., DON stated hospice MD sends an electronic script (e-script) to the pharmacy to have the morphine filled, that is why R1 received the correct dosage on 10/10/25 and LPN-A caught the medication error when the medication arrived that day at 3:00 p.m. and immediately called RN-B who gave the medication to inform her she gave a medication error. The DON stated she didn't consider this an error on their end since the hospice nurse wrote the error and their nurse just gave the medication according to their order. The DON did state she did provide Narcotic education to her staff which included standards of best practice when it comes to providing pain management, having a questioning attitude prior to administering medication and explaining the importance of checks and balance system. Sanford Policy revised 4/08/25, the location will have medication error rates of five percent or less and those residents are free of significant medication errors. When a medication error occurs, it will be reported promptly to the attending physician, resident and or responsible party. The policy indicated a significant medication error is one which causes the resident discomfort or jeopardizes his or her health and safety. SUGGESTED METHOD OF CORRECTION: (DON) or designee could review facility policies and procedures, educate staff and implement an ongoing monitoring system to ensure all resident orders are correctly transcribed and implemented as directed by physician orders.	21545		

Minnesota State Department of Health

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21545	Continued from page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Stillwater	**1119 OWENS STREET NORTH , STILLWATER, Minnesota, 55082**

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F0000	INITIAL COMMENTS On 10/29/25 to 10/30/25, a standard abbreviated survey was conducted at your facility by the Minnesota Department of Health. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed:H52076582C (2652923) with a deficiency issued at F760. 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 that substantial compliance with the regulations has been attained.	F0000		12/16/2025
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure liquid morphine (opioid analgesic used to treat severe pain) was administered per physician orders for 1 of 1 resident (R1) who was administered ten times the ordered dose. Findings include: R1's quarterly Minimum Data Set (MDS) dated 8/19/25, indicated diagnosis of anemia, heart failure, diabetes mellitus, and seizure disorder. The MDS indicated she was moderate cognitively intact and required assistance with activities of daily living. The MDS indicated R1	F0760	Preparation and execution of this response and Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and Plan of Correction is intended to constitute the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident R1 medication transcription error was identified and immediately discontinued. The physician and family were notified. Resident (R1) no longer resides at the facility. 2. How will other residents, having the potential to be	12/17/2025

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 reverse for further 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.

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

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F0760 SS = D	Continued from page 1 received scheduled pain medication and had a condition or chronic disease that may result in life expectancy of less than 6 months and received hospice care. R1's Care Plan dated 10/13/25, indicated R1 had acute and chronic pain/discomfort related to history of cerebral vascular accident and weakness. The care plan indicated nursing to evaluate the effectiveness of pain interventions after administration of pain medication, satisfaction with results, impact on functional ability and impact on cognition. The Care Plan further indicated R1 had terminal prognosis related to acute on chronic heart failure and was on hospice. R1's Physicians Orders dated 10/1025 indicated morphine sulfate (concentrate) oral solution 20 milligrams (mg)/ milliliters (ml), give 0.75 ml one hour as needed for pain or dyspnea. R1's Medication Administration Record (MAR) indicated on 10/10/25 R1 received 0.75 ml on 6:53 a.m. and 9:02 a.m. The order was increased to give 20mg/ml, give 1 ml as needed every one hour as needed for pain or dyspnea on 10/10/25, the MAR indicated this dose was never given. A Hospice Client -New Orders dated 10/10/25, ordered from hospice physician (over the phone) and transcribed by hospice nurse, registered nurse (HRN)-A to discontinue morphine 20mg/ml to give 1ml every one hour as needed (PRN). Begin morphine 20 mg(ml) give 15mg/7.5 ml oral/ sublingual every four hours for restlessness, and morphine 20 mg/ml may have 15 mg/7.5 ml every one hour for dyspnea or pain. (This went from the 0.75 ml dose R1 received to 7.5 ml which is ten times the dosage and transcribed incorrectly) The MAR indicated on 10/10/25 at 12:00 p.m., R1 received 7.5 ml of Morphine Sulfate concentrate for pain level of four. R1's MAR indicated she received Narcan 4 mg, also known as Naloxone (naloxone, a front-line defense in the nation’s overdose crisis. Naloxone is a life-saving drug that, when sprayed into the nose or injected, quickly reverses the powerful effects of opioids during an overdose) on 10/10/25, at 9:18 p.m. and 10:53 p.m. with all doses listed as effective. A Provider follow up Note Progress Note dated 10/10/25, indicated R1 presented with hypertensive heart disease with chronic diastolic heart failure, hospice care, hemiparesis, and expressive aphasia. The note indicated patient was seen multiple times today this afternoon and evening dule to medication error with administration of morphine sulfate. Extensive	F0760	Continued from page 1 affected by the same deficient practice, be identified? All residents in the facility receiving hospice care have the potential to be affected by the alleged deficient practice. As a result, a review of the physician orders and MAR for each hospice resident ordered was conducted on October 10, 2025, by the Director of Nursing. All hospice residents having orders for controlled substances were reviewed, and no discrepancies were identified. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained all licensed nurses have been educated on Good Samaritan policy relating to Prevention of Medication Errors, techniques to identify potential discrepancies, have a questioning attitude, and the communication process for clarification of physician’s orders. The Director of Nurses also reviewed Good Samaritan policy on Physician Orders with all nursing staff. The facility has put into place systemic improvement that will ensure second verification of hospice orders with the facility’s receiving nurses. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is sustained, the DNS/designee will conduct three random audits of physician orders for hospice residents weekly. Audit results will be brought to the monthly QAPI committee for recommendations on the need to increase or decrease audits to ensure substantial compliance is achieved. Audits will be completed per the recommendation of the QAPI committee for a period of no less than 90 days. 5. What is the date of completion? 12/17/2025	

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F0760 SS = D	Continued from page 2 discussion with patient's daughter, granddaughter. Spoke with hospice staff and hospice medical director. Narcan 4 mg was administered 4:00 p.m. and as of 8:30 pm. patient has not required another dose. Respiration rate (RR) remaining above 8 and around 8:00 p.m. was 18. Director of nursing and nursing staff are monitoring patient closely and checking RR every 15-30 minutes. At 8:40 p.m. patient was seen and had been repositioned. Breathing was shallower, rate appeared to be decreasing. Discussed with DON and we opted to give another dose of Narcan 4mg. Once given patients breathing appeared to improve, she was yawning and moving her mouth more and seemed less sedated. Nursing will be monitoring closely through the night. Again, extensive discussion with family at bedside, questions addressed, concerns addressed. Daughter plans on leaving to go home around 9:00 p.m. Was informed by text message that a third dose of Narcan was given just before 10:00 p.m. due changes in respirations. A requested MAR to the DON on 11/06/25, was not received until 11/18/25, by the facility administrator which indicated the dose that was given at 10:53 p.m. was in error and that was actually given at 4:50 p.m. and received it at 9:18 p.m. (which does not match what the NP indicated in her notes R1 received three doses of Narcan) Interview on 10/29/25 at 1:16 p.m., the director of nursing (DON) stated on 10/09/25, R1 was up in her wheelchair seemed perfectly fine normally arguing with me not wanting to go to bed then on 10/10/25, in the morning when I came in around 10:00 a.m. the nursing staff told me she had a stroke. The DON stated the hospice nurse came in and evaluated R1 and felt she had cardiac or CVA (cerebral vascular accident) and increased her morphine. The hospice nurse made a medication error and instead of transcribing morphine .75 ml to be given she transcribed 7.5 ml and the at 12:00 p.m., RN-A administered morphine sulfate 7.5 ml. from an existing bottle of morphine R1 had. The DON stated the evening nurse licensed practical nurse (LPN)-A noticed the medication error when the new morphine medication arrived with the prescription label that indicated to give .75ml instead of 7.5 ml. LPN-A then informed hospice and orders for Narcan were given and she corrected the transcription in the MAR to read to give 7.5 ml. The DON stated the first dose of Narcan was given after they repositioned R1 and she had a few episodes of apnea, and they were not sure if it was from the repositioning or the medication error, so they administered the Narcan and gave the other doses prophylactically. The DON stated she discussed with RN-B how they could learn from this and started	F0760		

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F0760 SS = D	Continued from page 3 education right away and explained how this was a transcription error and how we need to slow down and asses and question if this is an appropriate order especially if someone is taking an opioid. During interview on 10/30/25 at 10:27 a.m., hospice medical director stated she was informed the morning of 10/10/25 R1 was having stroke-like symptoms, and the hospice nurse increased her morphine due to signs of being uncomfortable, increased breathing and restlessness. Which were signs of pain and labored breathing. The medical director then stated she was informed the hospice nurse transcribed the order with the correct mg but the incorrect ml which was 7.5 and the facility nurse gave the morphine at 7.5 ml. The medical director stated R1 was not receiving much morphine and a dose like that could have killed her although the dose would be out of her system by 8 hours which in her case it did. During interview on 10/30/25 at 12:34 p.m., RN-B stated R1 was in distress the morning of 10/10/25, and the hospice nurse arrived and placed new orders to increase her morphine concentrate to 7.5 ml. RN-B stated R1 already had morphine on hand and at 12:00 p.m. she used what she had and in order to dose that much she had to use eight syringes which she thought was a lot but never said anything to anyone and administered the medication to R1. Later that day around 3:00 p.m. she received a phone call from the evening nurse LPN-A who informed her the new morphine medication arrived with the label reading .75 ml not 7.5 ml and realized it was a medication error. RN-B stated she immediately informed the DON and the Nurse Practitioner (NP) that were present in the building and Narcan was ordered as needed and 15-minute respiratory checks for R1. RN-B stated she did not recall receiving any re-education on the medication error from the DON. During interview on 10/30/25 at 1:05 p.m., LPN-B stated she worked on 10/11/25 and 10/12/25 and stated R1 stated in bed all weekend and she was unresponsive she did not open her eyes. LPN-B stated she knew not to ever give anyone more the 2ml of morphine and couldn't believe the order went through and fell through the cracks and was not caught until after R1 received the dosage. LPN-B stated they double check new orders with new admissions but not with orders that come through from hospice. During interview on 10/30/25 at 3:15 p.m., DON stated hospice MD sends an electronic script (e-script) to the pharmacy to have the morphine filled, that is why R1 received the correct dosage on 10/10/25 and LPN-A	F0760		

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F0760 SS = D	Continued from page 4 caught the medication error when the medication arrived that day at 3:00 p.m. and immediately called RN-B who gave the medication to inform her she gave a medication error. The DON stated she didn't consider this an error on their end since the hospice nurse wrote the error and their nurse just gave the medication according to their order. The DON did state she did provide Narcotic education to her staff which included standards of best practice when it comes to providing pain management, having a questioning attitude prior to administering medication and explaining the importance of checks and balance system. Sanford Policy revised 4/08/25, the location will have medication error rates of five percent or less and those residents are free of significant medication errors. When a medication error occurs, it will be reported promptly to the attending physician, resident and or responsible party. The policy indicated a significant medication error is one which causes the resident discomfort or jeopardizes his or her health and safety.	F0760		