



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 29, 2026

Administrator

GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY
3815 WEST BROADWAY AVENUE
ROBBINSDALE, MN 55422

RE: CCN: 245279

Cycle Start Date: August 25, 2026

Dear Administrator:

On September 1, 2026, we notified you a remedy was imposed. On September 21, 2026 the Minnesota Department of Health 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 September 9, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 16, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 1, 2026, 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 September 16, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 9, 2026, 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 Therefore, the NATCEP prohibition is rescinded.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.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/25/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY AVENUE , ROBBINSDALE, Minnesota, 55422			
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F0000	INITIAL COMMENTS On 8/4/26 through 8/5/26 and 8/24/26 through 8/25/26, standard abbreviated survey was conducted at your facility. 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. H52793291C(3091035), with a deficiency issued at F600 and F684. And, H52793571C(3122321) with no deficiency issued. 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			09/09/2026
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary			F0600	F600 (S/S = G): Free from Abuse and Neglect R1 is no longer residing on the affected memory care unit. R1's care plan will be reviewed by 9/8/2026 and updated to reflect his change in condition, current needs, and interventions related to safety and behavioral needs. R2's care plan will be reviewed by 9/8/2026 and updated to include individualized interventions addressing his history of resident-to-resident altercations, impaired cognition, and need for interventions to reduce the risk of further incidents. The interdisciplinary team reviewed both residents' care plans and current interventions on by 9/8/2026. The facility completed a review of residents residing on the memory care unit on by 9/8/2026 to identify residents with behaviors, cognitive impairment, wandering, or other risk factors that could place		09/09/2026

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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F0600 SS = G	Continued from page 1 seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to monitor and develop additional person-centered care plan interventions to protect a resident's right to be free from physical abuse for 1 of 4 residents (R1) resulted in actual harm when R1 who had dementia, hallucinations, agitation, and a habit of wandering into other residents' rooms on eight different occasions leading to resident-to-resident altercations. During the eighth incident, R1 suffered a Subdural Hematoma (a serious condition where blood collects between the layers of the brain after a head injury.) The severity of the injury resulted in the inability to walk, feed himself, and needed total care from staff. His prognosis was poor and required end of life hospice care. Findings include: R1's incident report dated 2/12/26 at 3:30 p.m., indicated R1 wandered into an unidentified resident's room and tried to lay in the bed. When the occupant found R1 he hit him on the right side of his face with a cane. Staff intervened and R1 had a 0.5 centimeter (cm) laceration on the right side of his face. R1's care plan dated 2/13/26, indicated he wandered around the unit and into other residents' rooms. Staff would intervene by removing him from the situation when necessary to protect other residents' rights and safety. Interventions included staff close observation and redirecting him back to the common area, offering food, toileting, letting him lay down for a nap, and providing distractions. R1's incident report dated 2/25/26 at 4:43 p.m., indicated R4 told staff R1 entered his room and he told him to leave. When R1 returned later he punched R4 on the chin. R1's incident report dated 3/3/26 at 5:15 a.m., indicated R1 entered R4's room and told him to get out. He then punched R1 hitting his right back shoulder. R1's incident report dated 4/11/26 at 6:12 p.m.,			F0600	Continued from page 1 themselves or other residents at risk for resident-to-resident altercations. Care plans were reviewed and updated as indicated to ensure individualized interventions are in place to address identified risks. Licensed nursing staff and members of the interdisciplinary team were re-educated regarding the facility's Abuse and Neglect policy, including the requirement to immediately protect residents following an incident, separate residents as necessary, complete an investigation, identify contributing factors, and develop or revise individualized care plan interventions to prevent recurrence. Education emphasized that care plans must be reviewed and updated following resident-to-resident altercations or changes in resident behavior/risk, even when the incident initially appears to be isolated. Education will be completed by 9/8/2026. To ensure compliance is sustained, add IDT will review weekly residents with behaviors and interventions initiated to ensure effectiveness. To ensure compliance is maintained, The Director of Nursing/designee will audit resident-to-resident altercation reports and related documentation weekly for four weeks, then monthly for two months, to verify that incidents are investigated, residents are protected, contributing factors are identified, and individualized care plan interventions are developed or revised as indicated. The audit will also verify that interventions are communicated to direct-care staff and implemented. Results of audits will be reviewed through the facility's Quality Assurance/Performance Improvement process. Any identified concerns will be addressed immediately through additional education, care plan revision, and/or other corrective action as indicated. Compliance date 9/9/2026.		09/09/2026

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F0600 SS = G	Continued from page 2 indicated R1 wandered into R2’s room. R1 was pushed by R2 causing him to fall backwards landing on his buttocks. R1’s incident report dated 5/6/26 at 5:10 p.m., indicated while staff were doing laundry they heard R4 yelling “get out of my room.” R4 pushed R1 down on to the floor hitting his hip and head. R1’s Psychopharmacological med/physical restraint note dated 5/7/26 at 10:32 a.m., indicated Psychotropics team reviewed medication and behaviors. They recommend staff to exercise him around the unit, place objects in front of other residents’ rooms to prevent him from entering. In addition, they considered increasing Depakote and decreasing Risperdal to decrease wandering. R1’s mood/behavior note dated 5/7/26 at 7:30 p.m., indicated R1 wandered into rooms R4 and R5's. Room R5 told him to get out. R1 was taken to the nursing station and monitored. R1’s care conference note dated 5/27/26 at 10:12 a.m., indicated his Risperidone decreased and Depakote dosage was increased on 5/8/26, in an effort to help with his restlessness and wandering. R1’s interdisciplinary note (IDT) dated 6/5/26 at 12:20 p.m., indicated R1 had incidents on 5/20/26 at 1:45 p.m., 5/28/26 at 12:45 p.m., and 6/2/26 at 10:30 a.m. Plan of care included sitting in the common area, offer to lay down after lunch, and the gradual dose reduction (GRD) of Risperidone. R1’s incident report dated 6/17/26 at 2:15 a.m., indicated R1 opened R4's door which had an alarm. Staff responded to the door alarm and found R1 by the nursing desk when R4 pushed staff out of the way and punched R1 on the cheek leading to a scratch and small laceration. R1’s progress note dated 6/18/26 at 3:21 p.m., indicated his Trazadone order changed to 25 mgs at 3:00 p.m. and increased bedtime dose to 150 mgs to improve sleeping patterns. R1’s nursing progress note dated 7/12/26 at 6:15			F0600			09/09/2026

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F0600 SS = G	Continued from page 3 p.m., indicated after dinner he walked into R2's room. R2 was standing in the doorway and pushed R1 down to the floor causing him to hit his head and the left side of his face. R1 complained about a headache and staff noted swelling on the left side of his face close to his eye. Staff provided scheduled Tylenol for pain and an ice pack for swelling. R1's incident report on 7/12/26 at 6:15 p.m., indicated he was wandering around the unit. When he reached R2's room he attempted to enter, but R2 was in the doorway and shoved him out of the room causing him to land on the floor hitting his head, injuring his forehead and the left side of his face. Patient complained about a headache. R1's quarterly Minimum Data Set (MDS), dated 7/30/26, indicated he had severe cognitive impairment. He required substantial assistance to dress, complete hygiene tasks, move in bed, and toilet. He walked independently and needed partial assistance to eat. His medications included antipsychotic, antidepressant, blood thinners, and anticonvulsant medications. R1's hospital discharge noted dated 8/3/26 indicated R1 presented to the emergency department on 7/14/26 with hip pain and head trauma following an altercation with another resident on 7/12/26. R1 underwent a head CT scan, which showed a four-millimeter subdural hematoma. R1 prognosis was poor and he discharged back to the nursing home on hospice on 7/31/26. R1's care plan dated 8/3/26, indicated prior to returning from the hospital his status changed to a terminal diagnosis, and the facility planned for hospice care to start when he returned. R1's face sheet dated 8/5/26, indicated he was admitted to the facility on 1/29/26. He had Alzheimer's disease, dementia with behavioral disturbances, on blood thinners for stroke prevention, high blood pressure, peripheral vascular disease (damaged blood vessels causing reduced blood flow to the legs and feet.) In addition, he had visuospatial deficit and neglect (caused by a stroke when the brain ignores all sensory input from one side of the brain).			F0600			09/09/2026

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F0600 SS = G	Continued from page 4 R2’s mood/behavior progress note dated 4/14/26 at 3:26 p.m., indicated R2 told facility staff R1 walked into his room weekly. Staff offered to place a stop banner across his doorway to prevent further incidents, but he declined. Staff encouraged him to call for help if it happened again. R2’s care plan dated 5/26/26, indicated he had impaired cognition, memory, process, and decision-making ability. Staff would monitor his condition and update the provider as needed. His care plan was not updated after the two incidents when he pushed R1 down on 4/11/26 and 7/12/26. R2’s quarterly MDS dated 7/30/26, indicated he had moderate cognitive impairment. He used a walker for ambulation. He was able to eat, toilet, move in his bed, transfer from chair to bed, and complete hygiene activities independently. He needed substantial help with showering and partial help with dressing. R2’s face sheet dated 8/5/26, indicated he was admitted to the facility on 1/21/25, he had Huntington's disease with Chorea (involves cognitive decline, inability to focus or make decisions.) In addition, he suffered with depression, mood swings, altered personality, trouble walking, speaking, and eating related to his spastic movements. During an interview on 8/5/26 at 11:11 a.m., nursing assistant (NA)-A stated he took care of R1. He was able to verbalize all the residents who did not get along with R1 caused by him walking into their rooms. He said the unit was laid out in a way for him to keep an eye on all the rooms and resident activities except when he was providing resident care. R2’s observation and interview on 8/5/26 at 11:22 a.m., found him lying on his bed. His movements were very rigid, and he needed to rock back and forth several times to sit up in bed. He denied having an incident with R1. There were no warning signs on his door to alert staff and residents not to enter his room. The unit was a locked memory care unit and built in an oval shape. The center of the unit was dining and common areas, and the outer edges were where the residents’ rooms were located. The nursing station was in the middle with a			F0600			09/09/2026

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F0600 SS = G	Continued from page 5 view of the entire unit and directly across from R2’s room. During an interview on 8/5/26 at 12:05 p.m., registered nurse (RN)-A stated after the 4/11/26, incident they tried to get R2 to add a stop banner that would go across his door to prevent future issues with R1. He declined because he liked to keep his door closed and it would interfere with his ability to close the door. After the 4/11/26, incident she was unsure why the residents were not placed on different units. She thought it was related to both residents needing a memory care unit and the facility only had one. When R1 returns from the hospital after his head injury he will be transferred to a different unit because he could no longer walk. During an interview on 8/5/26 at 2:07 p.m., the director of nursing (DON) stated after each incident they reviewed the facts during an Interdisciplinary Team (IDT) meeting. Even though R2 had pushed R1 down on 4/11/26 and identified R1 goes into his room weekly they thought R2’s behavior was a one off and did not require further care plan interventions. She added after each incident they should have reviewed R2’s behavior and developed interventions to prevent further physical abuse incidents with R1 and potentially other residents on the unit who might enter his room. During an interview on 8/5/26 at 2:17 p.m., family member (FM)-A stated R1 received intensive care for a couple of weeks at the hospital after falling and hitting his head on 7/12/26. Now R1 was unable to walk, required a pureed diet, total care, and slept most of the time. The hospital provider told him his outcome was poor and hospice care was initiated. He did not feel “great” about the incident and sadden R1 was no longer responsive and unable to return to his baseline prior to the fall. During an interview on 8/5/26 at 4:14 p.m., the administrator stated both resident’s care plans should have been updated with individualized interventions to prevent further incidents. The facility policy Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy & Rehab dated 4/7/25, indicated all residents would be free from abuse. After the incident staff would separate the residents, remove them from the location, call local police and			F0600			09/09/2026

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F0600 SS = G	Continued from page 6 911 as needed. After the incident the facility would investigate the situation while preventing further incidents. For resident-to-resident abuse staff would separate immediately to ensure a safe environment. Assign staff to complete an investigation and develop new care plan interventions.			F0600			09/09/2026
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to complete neurological assessments as indicated after a head injury sustained during a resident-to-resident altercation for 1 of 1 resident (R1) who sustained a significant head injury. R1 suffered actual harm resulting in a subdural hematoma (a collection of blood between the brain and its outer covering) and was sent to emergency department and returned on hospice care. Findings include: R1's July medication administration record (MAR) dated 7/12/26 through 7/14/26, indicated he received his scheduled Tylenol order for 1000 milligrams (mg) at 8:00 a.m. and 8:00 p.m. In addition, R1 had an order for additional as needed (PRN) Tylenol 1000 mgs once a day for pain but, no additional doses were given from 7/12/26 through 7/14/26. R1's nursing progress note dated 7/12/26 at 6:15 p.m., indicated after dinner he walked into R2's room. R2 was standing in the doorway and pushed R1 down to the floor causing him to hit his head and the left side of his face. He complained about a headache and staff noted swelling on the left side of his face close to his eye. Staff provided scheduled Tylenol for pain and an ice pack for swelling.			F0684	F684 (S/S = G): Quality of Care R1 is no longer residing at the facility. The medical record will be reviewed by the Director of Nursing/designee by 9/8/2026 and the circumstances surrounding the resident's change in condition were reviewed with the nursing leadership team. The facility completed a review of residents who had experienced a fall, head injury, or other change in condition requiring neurological monitoring within the previous 30 days. Medical records were reviewed to verify that required neurological assessments were completed, changes in condition were communicated to the provider, and provider orders were implemented. Any identified discrepancies were addressed immediately. All licensed nursing staff will be re-educated regarding the facility's Neurological Evaluation and Change in Condition policies by 9/8/2026. Education will include: Completing and documenting a baseline neurological assessment following a head injury. Completing neurological assessments at the frequency ordered by facility policy/provider orders. Comparing subsequent assessments with the resident's baseline and prior assessments for changes. Promptly notifying the provider of changes in condition or abnormal findings. Implementing and following provider orders. Re-contacting the provider when an ordered		09/09/2026

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F0684 SS = G	Continued from page 7 R1's skin assessment dated 7/12/26 at 6:49 p.m., indicated he had bruising on the left side of his face, left thigh, and hip. In addition, staff observed scratches on the left and right side of his face. R1's first neuro check on 7/12/26 at 7:39 p.m., indicated blood pressure was elevated at 182/65 (normal 90/60 to 120/80,) heart rate was 82 (60-100,) respirations were 18 (12 to 18,) and oxygen saturation was 96% (95 to 100) on room air. His pain level was eight (pain scale from zero the least amount of pain to 10 the worst). Pupils were reactive to light and level of consciousness was unchanged from his baseline. R1's second neuro check on 7/12/26 at 8:16 p.m., indicated his pain was at a five. Pupils were reactive to light, and his level of consciousness was at his baseline. R1's third neuro check on 7/12/26 at 8:56 p.m., his pain level was five. His pupils were reactive to light, and current level of consciousness was at baseline. R1's health status note dated 7/12/26 at 9:24 p.m., indicated he suffered a facial injury around his left upper eye and complained about a headache. He was given PRN pain medication. R1's fourth neuro check on 7/13/26 at 6:04 a.m., indicated during the overnight shift he did not have any pain, and his vital signs were within normal limits. His pupils were reactive to light, speech was clear, and he was able to move all extremities. R1's fifth neuro checks on 7/13/26 at 12:27 p.m., indicated his pain level was one, heart rate was 90, and the blood pressure was 103/43. He had spontaneous movement upon command. R1's health status note dated 7/13/26 at 6:56 p.m., indicated he had severe pain after the 7/12/26, fall. They administered PRN medication with poor results. The whole shift he was in bed with pain and "significant discomfort" during cares. He would "scream out with movement." The provider was notified, and a portable x-ray was ordered. His change in status required feeding assistance in bed			F0684	Continued from page 7 diagnostic test or treatment cannot be completed as ordered and obtaining further direction. Clearly communicating changes in condition, pending diagnostic testing, and provider notifications during shift-to-shift report. The Director of Nursing/designee will audit 100% of residents with a documented head injury, fall with potential head injury, or other condition requiring neurological monitoring for four weeks. Audits will verify completion of required neurological assessments, appropriate documentation, provider notification when indicated, implementation of orders, and follow-up when ordered diagnostic testing cannot be completed. Following the initial four-week audit period, audits will be completed monthly for two additional months. Audit results will be reviewed through the facility's Quality Assurance/Performance Improvement process. Any identified concerns will result in immediate corrective action, including re-education and/or additional monitoring as indicated. Compliance date 9/9/2026.		09/09/2026

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F0684 SS = G	Continued from page 8 and he continued to verbalize severe pain. R1's provider note dated 7/14/26 at 7:30 a.m., indicated he had uncontrolled pain. The provider ordered staff to send him to the emergency room for an evaluation. R1's SBAR (situation, background, assessment, and recommendation) note dated 7/14/26 at 7:37 a.m., registered nurse (RN)-B indicated R1's left hip pain worsened. He did not have any changes to his mental status or mobility. Signs of pain included occasional moaning, facial grimacing, and fidgeting. His POLST (Physician orders for Life-Sustaining treatment) indicated no CPR, allow for a natural death. Nursing care would focus on comfort only during last stages of life. Do not transfer to the hospital for life-sustaining treatment except in the event when pain control was not effective at the facility. R1's quarterly Minimum Data Set (MDS) dated 7/30/26, indicated he had severe cognitive impairment. He required substantial assistance to dress, complete hygiene tasks, move in bed, and toilet. He walked independently and needed partial assistance to eat. His medications included antipsychotic, antidepressant, blood thinners, and anticonvulsant medications. R1's hospital discharge noted dated 8/3/26 indicated R1 presented to the emergency department on 7/14/26 with hip pain and head trauma following an altercation with another resident on 7/12/26. R1 underwent a head CT scan, which showed a four-millimeter subdural hematoma. R1 prognosis was poor and he discharged back to the nursing home on hospice on 7/31/26. During an interview on 8/25/26 at 10:30 a.m., RN-D stated on 7/12/26, she found R1 on the floor and could not believe how much facial swelling had already occurred. She updated the family, her manager, and the provider who just wanted to monitor him. She was worried about R1 because he was on a blood thinner and she focused on his vital signs for any indication of internal bleeding. His cognition had not changed from baseline, and he complained about a headache for which she gave him Tylenol for pain. On 7/14/26, during afternoon shift report she was told R1 was okay. She informed			F0684			09/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/25/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY AVENUE , ROBBINSDALE, Minnesota, 55422			
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F0684 SS = G	Continued from page 9 the nursing assistant to call her for incontinent care so she could assess his injuries. When they turned him onto his side, he was in “significant pain” and held onto his left hip. She thought he had a possible hip fracture. She called primary care provider (PCP)-A who ordered a portable hip Xray. She attempted to contact the Xray company but could not send the fax or reach them online. She then left a message for her manager and updated the next shift nurse the Xray was not completed as ordered. During an interview on 8/25/26 at 1:08 p.m., RN-B stated she cared for R1 on 7/13/26, during the dayshift. She did not have any concerns regarding R1’s fall because he was at his baseline. He was placed in a wheelchair, and if he attempted to get up, they stopped him. She became concerned the next day on 7/14/26, when he did not get out of bed, had left hip swelling and was in “excruciating” pain. When they attempted to raise the head of the bed he yelled out and had tears in his eyes. She updated PCP-A on his current status and received an order to send him to the hospital for further treatment. During an interview on 8/25/26 at 1:26 p.m., PCP-A stated he was notified by staff on 7/12/26, after the fall. He could not recall the conversation with nursing staff but remembered R1’s cognition was at his baseline. He ordered the staff to complete neuro checks and continue to monitor. On 7/13/26, staff updated him regarding worsening hip pain. He ordered a portable Xray to be completed at the facility. If the staff were unable to get an Xray he would have expected them to call him back for further instructions. He added, R1 could tell staff if he had pain but was difficult to assess related to his severely impaired cognition. During an interview on 8/25/26, at 1:40 p.m., regional clinical director (RCD)-A indicated R1 had a bad outcome and they lost a resident. He reviewed R1’s chart and found a few missing neuro checks. The completed neuro checks did not indicate signs of a brain injury. Staff focused on his left hip pain and updated the provider. During an interview on 8/25/26 at 2:50 p.m., the director of nursing (DON) stated the nursing staff could have done a better job caring for R1 after his fall. When RN-B was unable to get the Xray completed she should have called the provider back.			F0684			09/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/25/2026	
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F0684 SS = G	Continued from page 10 During an interview on 8/26/26 at 9:04 a.m., RN-C stated she cared for R1 from 11:00 p.m. on 7/13/26 through 7:00 a.m. The previous nurse told her she called the provider but was unable to complete the portable Xray. She knew at that time the Xray company was closed. Her primary concern was a possible hip fracture and pain. Because of his POLST she knew if she called a provider at that time, they would not do anything, so she attempted to reach R1's family to get permission to send him to the hospital. R1's family did not answer the phone or return her call. The facility policy Change in Condition Evaluation dated 4/2/26, indicated when assessing for a change in condition, the nurse would review the residents: Medical diagnosis, and recent provider/consultation/interdisciplinary notes. Speak with other staff who cared for the residents along with family members. Next review the advanced directives and contact the family if clarifications were needed. Update the provider. The facility policy Neurological Evaluation-Rehab dated 3/20/26, indicated after an injury to a resident's head staff would: Document a baseline neuro check. Update the provider as needed. Process any new orders and continue to do neuro checks every 30 minutes for 2 hours, then every eight hours for 3 days. Compare current neuro check with the previous one for worsening symptoms. Notify the provider of any change in condition.			F0684			09/09/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/25/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY AVENUE , ROBBINSDALE, Minnesota, 55422			
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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 8/4/26 through 8/5/26 and 8/24/26 through 8/25/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaints were reviewed during the survey. H52793291C(3091035), H52793571C(3122321). Minnesota Department of Health is documenting the			20000			09/09/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/25/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY AVENUE , ROBBINSDALE, Minnesota, 55422			
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20000	Continued from page 1 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			09/09/2026



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Electronically delivered

September 1, 2026

Administrator

GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY
3815 WEST BROADWAY AVENUE
ROBBINSDALE, MN 55422

RE: CCN: 245279

Cycle Start Date: August 25, 2026

Dear Administrator:

On August 25, 2026, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 16, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 16, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 16, 2026.

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

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 \$13,343; 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 **September 16, 2026**, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility.

Therefore, [Facility Name()] will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from **September 16, 2026**. 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)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 25, 2027 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:

tamika.brown@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 Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@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)

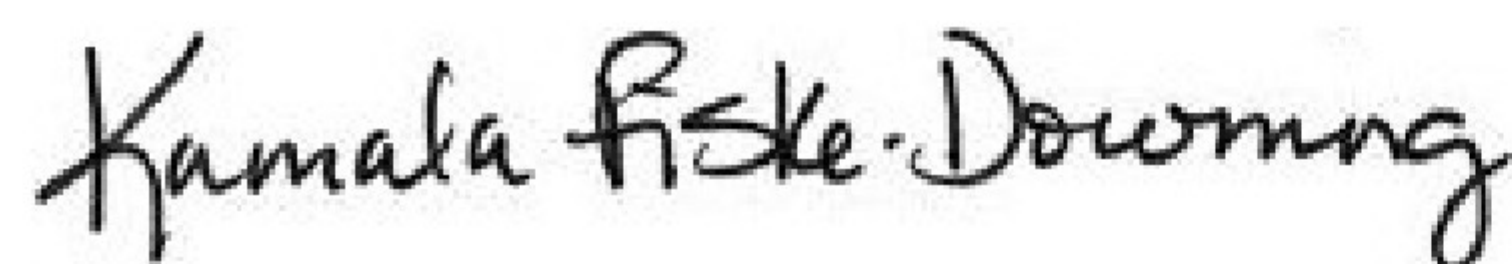
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments 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.

Feel free to contact me if you have questions.

Sincerely,



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

An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 1, 2026

Administrator

GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY
3815 WEST BROADWAY AVENUE
ROBBINSDALE, MN 55422

Re: Event ID: 2D064A-H1

Dear Administrator:

The above facility survey was completed on August 25, 2026 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads '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