



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 13, 2026

Administrator  
Good Samaritan Society - Bethany  
804 WRIGHT STREET  
BRAINERD, MN 56401

RE: CCN: 245500

Cycle Start Date: December 5, 2025

Dear Administrator:

On December 19, 2025, we notified you a remedy was imposed. On January 9, 2026 and January 11, 2026 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 9, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 1, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 19, 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 1, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 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 Therefore, the NATCEP prohibition is rescinded.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.

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

Feel free to contact me if you have 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](mailto:Kamala.Fiske-Downing@state.mn.us)  
Office: 651-201-4112



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January 13, 2026

Administrator

Good Samaritan Society - Bethany

804 WRIGHT STREET  
BRAINERD, MN 56401

Re: Reinspection Results  
Event ID: 1DC23D-H1

Dear Administrator:

On January 9, 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 4, 2025. At this time these correction orders were found corrected.

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](mailto:Kamala.Fiske-Downing@state.mn.us)  
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December 5, 2025

Administrator  
Good Samaritan Society - Bethany

804 WRIGHT STREET  
BRAINERD, MN 56401

RE: CCN:245500

Cycle Start Date: December 5, 2025

Dear Administrator:

On December 5, 2025 a survey was completed at your facility by the Minnesota Departments 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:

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](mailto: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, 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 5, 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 5, 2025 (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](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](mailto:Kamala.Fiske-Downing@state.mn.us)  
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Administrator

Good Samaritan Society - Bethany  
804 WRIGHT STREET  
BRAINERD, MN 56401

Re: State Nursing Home Licensing Orders

Event ID: 1D8543-H1

Dear Administrator:

The above facility was surveyed on December 5, 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](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:

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](mailto:annette.m.winters@state.mn.us)  
Mobile: (651) 558-7558

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

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245500</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>10/02/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>Good Samaritan Society - Bethany</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>804 WRIGHT STREET , BRAINERD, Minnesota, 56401</b>	
(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
F0000	<p>INITIAL COMMENTS</p> <p>On 9/30/25 through 10/2/25, a 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.</p> <p>The following complaints were reviewed. H55005202C (MN2625411) with a deficiency issued at F580 and F677</p> <p>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.</p> <p>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.</p>	F0000		01/02/2026
F0550 SS = D	<p>Resident Rights/Exercise of Rights</p> <p>CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights.</p> <p>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to</p>	F0550	<p>Disclaimer 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 constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.</p> <p>F550 SS= D</p> <p>On 12/10/25 the DNS and designees swept the whole building for residents to ensure that all residents, including R2, were in compliance with dignity in relation to dressing.</p> <p>All residents are at risk for having their dignity</p>	01/02/2026

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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F0550 SS = D	<p>Continued from page 1 quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights.</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure dignity was maintained for 1 of 3 residents (R2) reviewed for dignity related to dressing.</p> <p>Findings Include:</p> <p>R2's admission minimum data set (MDS) dated 6/25/25, indicated R2 was admitted on 5/19/25, was able to communicate clearly and understand others, moderate to mild cognitive impairment category, and had the following diagnoses: anxiety, mood disturbance, and dementia.</p> <p>R2's care plan last revised 8/29/25, indicated R2 required an assist of one for dressing related to activity intolerance, Dementia, and impaired balance. The care plan also indicated R2 had enhanced psychosocial well-being related to individualized daily routine and honoring personal preference.</p> <p>During observation on 10/1/25 at 9:40 a.m., the following events occurred:</p>	F0550	<p>Continued from page 1 compromised in relation to appropriate dressing. All residents have been observed and assessed to ensure dignity in dressing. Residents that have personal preferences according to dress have been careplanned.</p> <p>The DNS and designees will provide re-education for all staff on the importance of protecting resident dignity through appropriate dressing in accordance to resident preference. This training will be finished on 1/2/2026.</p> <p>The DNS and designees will audit 24 residents once a week for 6 weeks to ensure that staff have been properly re-educated on dignity in relation to dressing. Audits will be reviewed by the QAPI committee, and they will give direction for any further needed action.</p> <p>Completion Date 1/2/2026.</p>	

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F0550 SS = D	<p>Continued from page 2</p> <ul style="list-style-type: none"> <li>- 9:40 a.m., R2 was observed lying in bed in the highest position, wearing only a brief with his door wide open.</li> <li>- 9:55 a.m. nursing assistant (NA)-A was walking down R2's hall and walked right past R2's room which still had the door wide open leaving R2 exposed only in his brief.</li> <li>- 10:04 a.m. R2 sits up in his bed and begins to say "help, help"</li> <li>- 10:06 a.m. NA-B is observed walking past R2's room.</li> <li>- 10:12 a.m. an unidentified male staff is observed walking past R2's room.</li> <li>- 10:22 a.m. facility activity aid is observed entering R2's room and placing an activity calendar on his wall.</li> <li>- 10:35 a.m. NA-A walks past R2's room.</li> <li>- 10:38 a.m. NA-B walks past R2's room.</li> <li>- 10:39 a.m. facility social worker (SW)-A walks past R2's room.</li> <li>- 10:49 a.m. registered nurse (RN)-B walks past R2's room.</li> <li>- 10:50 a.m. SW-A walks past R2's room.</li> <li>- 10:52 a.m. RN-B walks past R2's room.</li> <li>- 11:00 a.m. an unidentified facility resident in a wheelchair, wheels past R2's room.</li> <li>- 11:03 a.m. NA-A walks past R2's room.</li> <li>- 11:05 a.m. NA-A walks past R2's room.</li> <li>- 11:10 a.m. NA-B walks past R2's room.</li> <li>- 11:12 a.m. an unidentified female resident walk past R2's room.</li> <li>- 11:18 a.m. an unidentified female enters R2's room and closes the door.</li> </ul> <p>On 10/1/25, at 11:18 a.m. NA-C stated she was a nursing assistant from hospice. NA-C stated when she arrived R2's door was wide open and R2 was lying in his bed in</p>	F0550		

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F0550 SS = D	<p>Continued from page 3 only a brief. R2 had no other clothing was on him, nor was there a blanket covering him. NA-C comes typically 3 x a week to provide cares, and this is typical to find R2 like this.</p> <p>On 10/1/25, at 10:23 a.m. during an interview R2 stated he would not want others to see him only in his brief.</p> <p>On 10/1/25, at 10:34 a.m., NA-B stated part of their role is to get residents up and assist them with activities of daily living (ADL), which would include getting the residents dressed. It would be a dignity issue if residents are exposed due to being left in only their brief with the door open.</p> <p>On 10/1/25, at 10:44 a.m. NA-A stated R2 is one of her assigned residents for the day and her shift had started at 6:00 a.m. R2 has not been assisted with any activities of daily living yet this morning, including repositioning, incontinence care, getting out of bed, or dressing. Leaving a resident in only their brief with the door open is a dignity concern and should not happen.</p> <p>On 10/1/25, at 11:48 a.m. director of nursing (DON) stated leaving a resident exposed in only their brief with the door open is a dignity concern. All residents have the right to have privacy and to be treated with dignity. All staff is responsible in ensuring residents are provided care with dignity.</p> <p>The facility Resident Dignity policy last reviewed 12/2024, indicated the facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality.</p> <p>The facility activities of Daily Living policy last reviewed 12/2024, indicated facility staff are to provide residents with appropriate treatment and services to maintain or improve abilities in activities of daily living for the well-being of mind, body, and soul.</p>	F0550		
F0677 SS = D	<p>ADL Care Provided for Dependent Residents</p> <p>CFR(s): 483.24(a)(2)</p>	F0677	<p>F677 SS= D</p> <p>On 12/10/2025 the DNS and designees swept the whole building for residents who require assistance with</p>	01/02/2026

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F0677 SS = D	<p>Continued from page 4</p> <p>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review failed to provide repositioning and toileting/incontinence cares for 1 of 3 residents (R2) reviewed for activities of daily living (ADL) and who were dependent on staff for ADL's.</p> <p>Findings Include:</p> <p>R2's admission minimum data set (MDS) dated 6/25/25, indicated R2 was admitted on 5/19/25, was able to communicate clearly and understand others, was moderate to mild cognitive impairment category, and had the following diagnoses: anxiety, mood disturbance, and dementia.</p> <p>R2's Braden Scale for Predicting Pressure Sore Risk dated 9/23/25 had a score of 14 indicating R2 is a moderate risk for skin breakdown. The intervention guide included frequent turning with a planned schedule and managing moisture.</p> <p>R2's care plan last revised 8/29/25, indicated R2 has bowel and bladder incontinence related to Alzheimer's Disease. The care plan indicated R2 will remain free from skin breakdown due to incontinence and brief use. RS was to be checked for incontinence every two hours. The care plan also indicted R2 has potential for pressure ulcer development related to disease process and immobility. Staff are to turn and reposition R2 in bed every 2 hours.</p> <p>During observation on 10/1/25 at 9:40 a.m., the following events occurred:</p> <ul style="list-style-type: none"> <li>- 9:40 a.m., R2 was observed lying in bed in the highest position, wearing only a brief with his door wide open.</li> <li>- 9:55 a.m. nursing assistant (NA)-A was walking down R2's hall and walked right past R2's room which still had the door wide open leaving R2 exposed only in his brief.</li> </ul>	F0677	<p>Continued from page 4</p> <p>ADL's, including R2, to ensure each resident had appropriate repositioning and toileting careplans in place.</p> <p>All residents who require assistance with ADL's are at risk for lack of assistance according to careplan. Residents who require assistance have individualized careplans to outline their specific needs. Individual interventions are assessed at admission/re-admission, with each change in condition, and at least quarterly.</p> <p>The DNS and designees will provide re-education to all staff regarding ADL care, specifically toileting and repositioning, to be provided in accordance with their individualized careplan. Education will be completed by 1/2/2026.</p> <p>The DNS and designees will audit 10 residents weekly for 6 weeks that require assistance with ADL's to ensure that toileting and repositioning are completed in accordance with the resident's individualized careplan. Audits will be reviewed by the QAPI committee, and they will give direction for any further needed action.</p>	

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245500</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>10/02/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>Good Samaritan Society - Bethany</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>804 WRIGHT STREET , BRAINERD, Minnesota, 56401</b>	
(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
F0677 SS = D	<p>Continued from page 5</p> <ul style="list-style-type: none"> <li>- 10:04 a.m. R2 sits up in his bed and begins to say "help, help"</li> <li>- 10:06 a.m. NA-B is observed walking past R2s room.</li> <li>- 10:35 a.m. NA-A walks past R2's room.</li> <li>- 10:38 a.m. NA-B walks past R2's room.</li> <li>- 10:49 a.m. registered nurse (RN)-B walks past R2's room.</li> <li>- 10:50 a.m. SW-A walks past R2's room.</li> <li>- 10:52 a.m. RN-B walks past R2's room.</li> <li>- 11:03 a.m. NA-A walks past R2's room.</li> <li>- 11:05 a.m. NA-A walks past R2's room.</li> <li>- 11:10 a.m. NA-B walks past R2's room.</li> <li>- 11:8 a.m. an unidentified female enters R2's room and closes the door.</li> </ul> <p>On 10/1/25, at 11:18 a.m. NA-C stated she was a nursing assistant from hospice. NA-C stated when she arrived R2's door was wide open and R2 was lying in his bed in only a brief. R2 had no other clothing was on him, nor was there a blanket covering him. NA-C stated R2's brief was saturated with urine and feces. The brief was so saturated with urine that the sheet R2 was lying on was also soaked in urine. NA-C comes typically 3 x a week to provide cares, and this is common to find R2 like this.</p> <p>On 10/1/25, at 10:23 a.m. during an interview R2 stated he would not want others to see him only in his brief.</p> <p>On 10/1/25, at 10:34 a.m., NA-B stated part of their role is to get residents up and assist them with activities of daily living (ADL), which would include getting the residents dressed. It would be a dignity issue if residents are exposed due to being left in only their brief with the door open. She has not provided any care for R2 so far this shift.</p> <p>On 10/1/25, at 10:44 a.m. NA-A stated R2 is one of her assigned residents for the day and her shift had started at 6:00 a.m. R2 has not been assisted with any</p>	F0677		

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245500</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>10/02/2025</b>
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F0677 SS = D	<p>Continued from page 6 activities of daily living yet this morning, including repositioning, incontinence care, getting out of bed, or dressing. R2 is to have his brief checked and changed at least every 2 hours.</p> <p>On 10/1/25, at 11:48 a.m. director of nursing (DON) stated leaving a resident in their brief for greater than 2 hours and not repositioning if needed increases the risk for skin breakdown. Staff are to be following the individual residents care plan and if it directs staff to check and change a resident and reposition every 2 hours then staff are to be doing so. R2 should have been assisted with incontinence and repositioned at a minimum every 2 hours.</p> <p>The facility Bowel and Bladder: Evaluation Assessment, Toileting Program policy last reviewed 5/2025, indicated based on the resident's comprehensive assessment, the location will ensure that each resident with bowel or bladder incontinence will receive appropriate treatment and services to restore as much normal bowel or bladder functioning as possible.</p> <p>The facility Skin Assessment Pressure Ulcer Prevention and Documentation Requirements policy last reviewed 4/2025, indicated residents who are unable to reposition themselves independently, as indicated on the Sit-Stand-Walk Data Collection Tool UDA, should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is required for those residents unable to position themselves and is based on nutrition, hydration, incontinence, diagnoses, mobility, and observation of the resident's skin over a period of time.</p> <p>The facility activities of Daily Living policy last reviewed 12/2024, indicated facility staff are to provide residents with appropriate treatment and services to maintain or improve abilities in activities of daily living for the well-being of mind, body, and soul.</p> <p>The facility Resident Dignity policy last reviewed 12/2024, indicated the facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality.</p>	F0677		

Minnesota State Department of Health

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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On 9/30/25 to 10/2/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p>	20000		01/02/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota State Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>10/02/2025</b>
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20000	Continued from page 1  The following complaints were reviewed. H55005202C(MN2625411) with a licensing order issued at 20920 and 21805.  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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction.  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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.  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.	20000		
20920	Rehab - ADLs  CFR(s): MN Rule 4658.0525 Subp. 6 B  Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:	20920	Corrected	01/02/2026

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20920	<p>Continued from page 2</p> <p>B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure dignity was maintained for 1 of 3 residents (R2) reviewed for dignity related to dressing.</p> <p>Findings Include:</p> <p>R2's admission minimum data set (MDS) dated 6/25/25, indicated R2 was admitted on 5/19/25, was able to communicate clearly and understand others, was moderate to mild cognitive impairment category, and had the following diagnoses: anxiety, mood disturbance, and dementia.</p> <p>R2's Braden Scale for Predicting Pressure Sore Risk dated 9/23/25 had a score of 14 indicating R2 is a moderate risk for skin breakdown. The intervention guide included frequent turning with a planned schedule and managing moisture.</p> <p>R2's care plan last revised 8/29/25, indicated R2 has bowel and bladder incontinence related to Alzheimer's Disease. The care plan indicated R2 will remain free from skin breakdown due to incontinence and brief use. RS was to be checked for incontinence every two hours. The care plan also indicted R2 has potential for pressure ulcer development related to disease process and immobility. Staff are to turn and reposition R2 in bed every 2 hours.</p> <p>During observation on 10/1/25 at 9:40 a.m., the following events occurred:</p> <ul style="list-style-type: none"> <li>- 9:40 a.m., R2 was observed lying in bed in the highest position, wearing only a brief with his door wide open.</li> <li>- 9:55 a.m. nursing assistant (NA)-A was walking down R2's hall and walked right past R2's room which still had the door wide open leaving R2 exposed only in his brief.</li> <li>- 10:04 a.m. R2 sits up in his bed and begins to say "help, help"</li> </ul>	20920		

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20920	<p>Continued from page 3</p> <ul style="list-style-type: none"> <li>- 10:06 a.m. NA-B is observed walking past R2s room.</li> <li>- 10:35 a.m. NA-A walks past R2's room.</li> <li>- 10:38 a.m. NA-B walks past R2's room.</li> <li>- 10:49 a.m. registered nurse (RN)-B walks past R2's room.</li> <li>- 10:50 a.m. SW-A walks past R2's room.</li> <li>- 10:52 a.m. RN-B walks past R2's room.</li> <li>- 11:03 a.m. NA-A walks past R2's room.</li> <li>- 11:05 a.m. NA-A walks past R2's room.</li> <li>- 11:10 a.m. NA-B walks past R2's room.</li> <li>- 11:8 a.m. an unidentified female enters R2's room and closes the door.</li> </ul> <p>On 10/1/25, at 11:18 a.m. NA-C stated she was a nursing assistant from hospice. NA-C stated when she arrived R2's door was wide open and R2 was lying in his bed in only a brief. R2 had no other clothing was on him, nor was there a blanket covering him. NA-C stated R2's brief was saturated with urine and feces. The brief was so saturated with urine that the sheet R2 was lying on was also soaked in urine. NA-C comes typically 3 x a week to provide cares, and this is common to find R2 like this.</p> <p>On 10/1/25, at 10:23 a.m. during an interview R2 stated he would not want others to see him only in his brief.</p> <p>On 10/1/25, at 10:34 a.m., NA-B stated part of their role is to get residents up and assist them with activities of daily living (ADL), which would include getting the residents dressed. It would be a dignity issue if residents are exposed due to being left in only their brief with the door open. She has not provided any care for R2 so far this shift.</p> <p>On 10/1/25, at 10:44 a.m. NA-A stated R2 is one of her assigned residents for the day and her shift had started at 6:00 a.m. R2 has not been assisted with any activities of daily living yet this morning, including repositioning, incontinence care, getting out of bed,</p>	20920		

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20920	<p>Continued from page 4 or dressing. R2 is to have his brief checked and changed at least every 2 hours.</p> <p>On 10/1/25, at 11:48 a.m. director of nursing (DON) stated leaving a resident in their brief for greater than 2 hours and not repositioning if needed increases the risk for skin breakdown. Staff are to be following the individual residents care plan and if it directs staff to check and change a resident and reposition every 2 hours then staff are to be doing so. R2 should have been assisted with incontinence and repositioned at a minimum every 2 hours.</p> <p>The facility Bowel and Bladder: Evaluation Assessment, Toileting Program policy last reviewed 5/2025, indicated based on the resident's comprehensive assessment, the location will ensure that each resident with bowel or bladder incontinence will receive appropriate treatment and services to restore as much normal bowel or bladder functioning as possible.</p> <p>The facility Skin Assessment Pressure Ulcer Prevention and Documentation Requirements policy last reviewed 4/2025, indicated residents who are unable to reposition themselves independently, as indicated on the Sit-Stand-Walk Data Collection Tool UDA, should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is required for those residents unable to position themselves and is based on nutrition, hydration, incontinence, diagnoses, mobility, and observation of the resident's skin over a period of time.</p> <p>The facility activities of Daily Living policy last reviewed 12/2024, indicated facility staff are to provide residents with appropriate treatment and services to maintain or improve abilities in activities of daily living for the well-being of mind, body, and soul.</p> <p>The facility Resident Dignity policy last reviewed 12/2024, indicated the facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing</p>	20920		

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20920	Continued from page 5 (DON), or designee, could review applicable policies and procedures to ensure residents are free from neglect and abuse and provide staff education regarding repositioning techniques, and assist with incontinence care for resident's dependent on staff for assist. The Quality Assurance Performance Improvement (QAPI) committee could monitor ongoing compliance.	20920		
21805	<p>TIME FOR CORRECTION: Twenty-one (21) days.</p> <p>Patients &amp; Residents of HC Fac. Bill of Rights</p> <p>CFR(s): MN St. Statute 144.651 Subd. 5</p> <p>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure dignity was maintained for 1 of 3 residents (R2) reviewed for dignity related to dressing.</p> <p>Findings Include:</p> <p>R2's admission minimum data set (MDS) dated 6/25/25, indicated R2 was admitted on 5/19/25, was able to communicate clearly and understand others, moderate to mild cognitive impairment category, and had the following diagnoses: anxiety, mood disturbance, and dementia.</p> <p>R2's care plan last revised 8/29/25, indicated R2 required an assist of one for dressing related to activity intolerance, Dementia, and impaired balance. The care plan also indicated R2 had enhanced psychosocial well-being related to individualized daily routine and honoring personal preference.</p> <p>During observation on 10/1/25 at 9:40 a.m., the following events occurred:</p> <ul style="list-style-type: none"> <li>- 9:40 a.m., R2 was observed lying in bed in the highest position, wearing only a brief with his door wide open.</li> <li>- 9:55 a.m. nursing assistant (NA)-A was walking down R2's hall and walked right past R2's room which still</li> </ul>	21805	Corrected	01/02/2026

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21805	<p>Continued from page 6</p> <p>had the door wide open leaving R2 exposed only in his brief.</p> <ul style="list-style-type: none"> <li>- 10:04 a.m. R2 sits up in his bed and begins to say "help, help"</li> <li>- 10:06 a.m. NA-B is observed walking past R2's room.</li> <li>- 10:12 a.m. an unidentified male staff is observed walking past R2's room.</li> <li>- 10:22 a.m. facility activity aid is observed entering R2's room and placing an activity calendar on his wall.</li> <li>- 10:35 a.m. NA-A walks past R2's room.</li> <li>- 10:38 a.m. NA-B walks past R2's room.</li> <li>- 10:39 a.m. facility social worker (SW)-A walks past R2's room.</li> <li>- 10:49 a.m. registered nurse (RN)-B walks past R2's room.</li> <li>- 10:50 a.m. SW-A walks past R2's room.</li> <li>- 10:52 a.m. RN-B walks past R2's room.</li> <li>- 11:00 a.m. an unidentified facility resident in a wheelchair, wheels past R2's room.</li> <li>- 11:03 a.m. NA-A walks past R2's room.</li> <li>- 11:05 a.m. NA-A walks past R2's room.</li> <li>- 11:10 a.m. NA-B walks past R2's room.</li> <li>- 11:12 a.m. an unidentified female resident walk past R2's room.</li> <li>- 11:18 a.m. an unidentified female enters R2's room and closes the door.</li> </ul> <p>On 10/1/25, at 11:18 a.m. NA-C stated she was a nursing assistant from hospice. NA-C stated when she arrived R2's door was wide open and R2 was lying in his bed in only a brief. R2 had no other clothing was on him, nor was there a blanket covering him. NA-C comes typically 3 x a week to provide cares, and this is typical to find R2 like this.</p> <p>On 10/1/25, at 10:23 a.m. during an interview R2 stated</p>	21805		

Minnesota State Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>10/02/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>Good Samaritan Society - Bethany</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>804 WRIGHT STREET , BRAINERD, Minnesota, 56401</b>	
(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
21805	<p>Continued from page 7 he would not want others to see him only in his brief.</p> <p>On 10/1/25, at 10:34 a.m., NA-B stated part of their role is to get residents up and assist them with activities of daily living (ADL), which would include getting the residents dressed. It would be a dignity issue if residents are exposed due to being left in only their brief with the door open.</p> <p>On 10/1/25, at 10:44 a.m. NA-A stated R2 is one of her assigned residents for the day and her shift had started at 6:00 a.m. R2 has not been assisted with any activities of daily living yet this morning, including repositioning, incontinence care, getting out of bed, or dressing. Leaving a resident in only their brief with the door open is a dignity concern and should not happen.</p> <p>On 10/1/25, at 11:48 a.m. director of nursing (DON) stated leaving a resident exposed in only their brief with the door open is a dignity concern. All residents have the right to have privacy and to be treated with dignity. All staff is responsible in ensuring residents are provided care with dignity.</p> <p>The facility Resident Dignity policy last reviewed 12/2024, indicated the facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality.</p> <p>The facility activities of Daily Living policy last reviewed 12/2024, indicated facility staff are to provide residents with appropriate treatment and services to maintain or improve abilities in activities of daily living for the well-being of mind, body, and soul.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure residents are free from neglect and abuse and provide staff education regarding providing care in a dignified manner and promoting residents privacy. The Quality Assurance Performance Improvement (QAPI) committee could monitor ongoing compliance.</p>	21805		

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21805	Continued from page 8 TIME FOR CORRECTION: Twenty-one (21) days.	21805		