DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 1, 2026

Administrator
Good Samaritan Society - Mountain Lake
745 BASINGER MEMORIAL DRIVE
MOUNTAIN LAKE, MN 56159

RE: CCN: 245549

Cycle Start Date: April 29, 2026

Dear Administrator:

On May 20, 2026, we notified you a remedy was imposed. On June 26, 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 June 26, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 29, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 20, 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 July 29, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 26, 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 Therefore, the NATCEP prohibition is rescinded.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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division

**Minnesota Department of Health**
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 20, 2026

Administrator
Good Samaritan Society - Mountain Lake
745 BASINGER MEMORIAL DRIVE
MOUNTAIN LAKE, MN 56159

Re: Event ID: 22F2A8-H1

Dear Administrator:

The above facility survey was completed on April 29, 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,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division
**Minnesota Department of Health**
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 20, 2026

Administrator
Good Samaritan Society - Mountain Lake
745 BASINGER MEMORIAL DRIVE
MOUNTAIN LAKE, MN 56159

RE: CCN:  245549

Cycle Start Date: April 29, 2026

Dear Administrator:

On April 29, 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), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other 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),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)).

**REMEDIES**

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 29, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 29, 2026.  They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 29, 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.

- Civil money penalty. (42 CFR 488.430 through 488.444)

**NURSE AIDE TRAINING PROHIBITION**

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 29, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

**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:

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Health Regulation Division

Minnesota Department of Health
1400 E. Lyon St.
Marshall, MN 56258
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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.

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 29, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

**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.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division
**Minnesota Department of Health**
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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May 20, 2026

Administrator
Good Samaritan Society - Mountain Lake
745 BASINGER MEMORIAL DRIVE
MOUNTAIN LAKE, MN 56159

Re: Event ID: 22F2A8-H1

Dear Administrator:

The above facility survey was completed on April 29, 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,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division
**Minnesota Department of Health**
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/29/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **Good Samaritan Society - Mountain Lake** | **745 BASINGER MEMORIAL DRIVE , MOUNTAIN LAKE, Minnesota, 56159** |

| (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 | INITIAL COMMENTS<br><br>On 4/22/26 through 4/29/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed:<br><br>H55491313C (2983235) an unrelated deficiency was issued at F656.<br><br>H55499561C (2964767) a deficiency was issued at F760 at HARM PAST NON-COMPLIANCE.<br><br>H55494900C (2729295) a deficiency was issued at F689 at HARM PAST NON-COMPLIANCE.<br><br>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.<br><br>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 | | 05/21/2026 |
| F0689<br>SS = G | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that -<br><br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. | F0689 | "Past Noncompliance - no plan of correction required" | 05/21/2026 |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/29/2026 |
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| F0689 SS = G | Continued from page 1<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and document review the facility failed to follow care planned fall interventions for 1 of 3 residents (R5) reviewed for falls. This resulted in actual harm when R5 fell and required a visit to the emergency department resulting in a fractured left femur and needed surgical intervention. The facility had implemented appropriate corrective action prior to the onsite investigation, so the deficiency is being cited at past non-compliance.<br><br>Findings include:<br><br>R5's quarterly Minimum Data Set (MDS) dated 1/2/26, indicated R5 had moderate cognitive impairment, needed substantial to maximal assistance with toileting, and needed partial to moderate assistance with toilet transfers<br><br>R5's Face Sheet dated 6/23/23, indicated R5 had dementia.<br><br>R5's care plan with intervention revision dated 7/16/25, indicated R5 had an actual fall with no injury related to poor vision and unsteady gait. Intervention included: staff to toilet resident during 4:00 a.m. rounding. R5's fall tool dated 8/31/25, indicated R5 was at high risk for falls.<br><br>R5's Emergency Department (ED) note dated 1/28/26, indicated R5 had a fall resulting in a closed fracture of left hip.<br><br>R5's Sanford Accountability For Excellence (SAFE) Event- Incident Report dated 1/28/26, indicated at 6:15 a.m., R5 had a fall, was sent to the ED and X-ray verified a left hip fracture.<br><br>R5's progress notes dated 1/28/26:<br><br>6:15 a.m., R5 was found on the floor and stated she was trying to use the bathroom.<br><br>6:30 a.m., indicated R5 was complaining of left hip, knee, and leg pain.<br><br>7:51 a.m. R5 was sent into the ED.<br><br>9:58 a.m., facility was notified R5 had a left hip fracture.<br><br>R5's Orthopedic Surgery note dated 1/29/26, indicated R5 had a closed displaced left femoral | F0689 | | 05/21/2026 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/29/2026 |
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| F0689 SS = G | Continued from page 2<br>neck fracture and needed a left hip hemiarthroplasty (femoral head joint replacement).<br><br>During an interview on 4/22/26 at 3:15 p.m., R5 stated she had a fall in 1/2026 but could not recall the date. R5 hurt her left leg and had to go to the hospital. Before the fall R5 was trying to get up to go to the bathroom. R5 did not think staff offered to take her to the bathroom before her fall.<br><br>On 4/23/26 at 12:30 p.m., nursing assistant (NA)-A stated on 1/28/26 between 2:00 a.m. and 4:00 a.m., NA-A checked on R5 but did offer toilet assistance to R5. NA-A stated she was not aware R5 needed to be toileted during 4:00 a.m. rounds because it was not on R5's Kardex. NA-A stated she did not look at the care plan prior to her shift. NA-A stated she should have looked at R5's care plan prior to caring for R5.<br><br>On 4/29/26 at 2:40 p.m., nurse practitioner (NP)-A stated the fall R5 had could have been prevented if staff would have followed the care plan and toileted R5 during 4:00 a.m. rounds.<br><br>On 4/29/26 at 3:42 p.m., director of nursing (DON) stated staff are expected to follow resident care plans. DON put the intervention to toilet R5 during 4:00 a.m. rounds in R5's care plan. DON thought the intervention was on R5's Kardex but it was not. The facility now double checks the Kardex to ensure all interventions are in place.<br><br>On 4/29/26 at 4:07 p.m., administrator stated staff are expected to follow the care plan. The administrator was made aware R5's toileting intervention was not on the Kardex after discussion with the DON.<br><br>The facility Fall Prevention and Management policy revised 3/31/26, indicated the facility would communicate fall interventions to prevent a fall per the 24-hour report, care plan and Kardex.<br><br>The facility implemented corrective action to prevent recurrence by 2/3/26 when the facility completed the following: provided education to all nursing staff on updating interventions, following care plans, and fall risks, reviewed all high fall risk residents and updated care plans, and completed high fall risk audits to ensure fall interventions were care planned and pulling to the resident Kardex. Verification of corrective action was confirmed by observation, interview, and document review on 4/22/26 and 4/29/26. | F0689 | | 05/21/2026 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/29/2026 |
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| F0760 SS = G | Residents are Free of Significant Med Errors<br><br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br><br>§483.45(f)(2) Residents are free of any significant medication errors.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and document review, the facility failed to ensure medications were administered to the correct resident for 1 of 3 residents (R3) reviewed for medication errors. This failure resulted in actual harm for R3 when she developed bradycardia (abnormally slow heart rate) which required ongoing monitoring and intravenous therapy in the emergency department (ED). The facility had implemented appropriate corrective action prior to the onsite investigation, so the deficiency is being cited at past non-compliance.<br><br>R3's Face Sheet dated 10/23/25, indicated R3 had dementia and Alzheimer's Disease.<br><br>R3's Sanford Accountability For Excellence (SAFE) Event Incident Report dated 3/25/26, indicated R3 was found with another resident's crushed medications in a drink. R3 became sleepy and was sent to ED.<br><br>R3's Weights and Vitals Summary dated 3/25/26, indicated R3's pulse was 47 beats per minute (BPM) at 6:11 p.m. At 6:44 p.m., R1's pulse was 40 bpm.<br><br>On 3/25/26 R3's progress note indicated:<br><br>5:23 p.m., R3 was sitting at the dining table across from another resident who had crushed medications in a glass of liquid. R3 was seen with the glass of liquid in her hand. After ten minutes, R3 was sleeping at the dining room table.<br><br>5:45 p.m., poison control was called due to R3 getting an unknown amount of high dose blood pressure medication, facility was directed to send R3 to the ED if her pulse dropped below 45 consistently.<br><br>6:30 p.m., pulse continued to decrease 42-44 BPM and at times dropped to upper 30's, R3 was sent to ED for hydration. | F0760 | "Past Noncompliance - no plan of correction required" | 05/21/2026 |

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| F0760 SS = G | Continued from page 4<br>R1's Emergency Department Note dated 3/25/26, indicated R3 was at the table in the dining room and took another residents medications: valproic acid (seizure medication) 125 milligrams (mg)/ 5 milliliters (mL); carbidopa/ levodopa (Parkinson's disease medication) 25/100mg; glycopyrrolate (peptic ulcer medication) 1mg; metoprolol (high blood pressure medication) 75mg; and Remeron (antidepressant) 7.5mg. R3 was lethargic and diagnosed with medication overdose. R3 was given intravenous normal saline 500 mL bolus with glucagon (diabetes medication) 5mg. R3's pulse had dropped to 37bpm consistent with metoprolol ingestion.<br><br>During an interview on 4/22/26 at 4:13 p.m., registered nurse (RN)-A stated he got R4's medications ready in a glass of liquid and set the cup in front of R4 then RN-A walked away. R3 grabbed R4's glass of crushed medications and drank out of the glass. R3's pulse started to decrease so R3 was sent to the ED. RN-A stated he should not have left R4 alone with his medications. RN-A stated he should have stayed with R4 until all of his medications were taken.<br><br>On 4/29/26 at 2:40 p.m., nurse practitioner (NP)- A stated if the facility would have followed the medication administration policy and procedure R3 would not have ingested R4's medications and would not have been sent to the ED. R3's pulse was normally around 60 bpm so a pulse of 37 bpm was concerning.<br><br>On 4/29/26 at 3:01 p.m., consultant pharmacist (CP)-A stated R3's pulse being above 50 bpm would not have been concerning but a pulse of 37 bpm was concerning. Glucagon was given to R3 to reverse the effects of the metoprolol overdose.<br><br>On 4/29/26 at 3:42 p.m., director of nursing (DON) stated staff would be expected to stay with the resident when taking medications unless they were assessed and had orders to take medications alone. RN-A should have never left R4's medications on the table, RN-A should have stayed with R4 until his medications were taken.<br><br>On 4/29/26 at 4:07 p.m., administrator stated staff were expected to stay with residents when giving medications until they were taken, unless the resident was assessed and safe to take medications alone. R4 was not safe to take medications alone.<br><br>The facility Medication Administration policy revised 3/30/26, indicated staff would not leave medications with a resident unless a specific physician order was | F0760 | | 05/21/2026 |

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| F0760 SS = G | Continued from page 5<br>in place to do so and the resident was evaluated for self- administration of medications.<br><br>The facility implemented corrective action to prevent recurrence by 3/31/26, when the facility completed the following: provided education to all staff members responsible for medication administration, which included administration of medications and self-administration of medication, observed all residents with self- administration of medication orders and updated care plans, and completed medication administration audits. Verification of corrective action was confirmed by observation, interview, and document review on 4/22/26 through 4/29/26. | F0760 | | 05/21/2026 |
| F0656 SS = D | Develop/Implement Comprehensive Care Plan<br><br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br><br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative(s)-<br><br>(A) The resident's goals for admission and desired outcomes. | F0656 | The following disclaimer should be written in the “Provider’s Plan of Correction” column prior to responding to the first survey citation: 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 constitute the center’s allegation of compliance in accordance with section 7305 of the State Operations Manual.<br><br>F 0656 Develop/Implement Comprehensive Care Plan<br><br>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>The facility SW, DON, ADM, QAPI leader, and case managers met and reviewed R1, R2, & R3 status, triggers and vulnerability and an individualized assessment of the resident’s susceptibility to abuse was completed. R1, R2, & R3 Care Plan were updated to include specific, measurable interventions to minimize the risk of abuse and/or vulnerabilities as mandated by the Minnesota Vulnerable Adults Act (MNVAA).<br><br>How will other residents, having the potential to be affected by the same deficient practice, be identified?<br><br>All residents residing at this facility have the | 05/29/2026 |

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| F0656 SS = D | Continued from page 6<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br><br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(iii) Be culturally-competent and trauma-informed.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review the facility failed to develop/implement the care plan to include vulnerabilities for 3 of 3 residents (R1, R2, R3) who's care plans were reviewed for comprehension.<br><br>R1<br><br>R1's Face Sheet dated 2/16/22, indicated R1 had dementia and mild cognitive impairment.<br><br>R1's Minnesota Vulnerable Adult Assessment (MVAA) dated 2/19/26, indicated R1 was unable to report abuse/ neglect concerns, defend self from verbal/physical attacks, and manage financial affairs.<br><br>R1's care plan dated 4/29/26, did not identify or include the following vulnerability findings for R1: unable to report abuse/ neglect concerns, defend self from verbal/physical attacks, and manage financial affairs.<br><br>R2<br><br>R2's Face Sheet dated 10/9/2023, indicated R2 had mild cognitive impairment.<br><br>R2'S MVAA dated 2/27/26, indicated R2 was unable to defend self from verbal and physical attacks and was unable to manage financial affairs.<br><br>R2's care plan dated 4/29/26, did not identify or include the following vulnerability findings for R2: unable to defend self from verbal/physical attacks and manage financial affairs.<br><br>R3<br><br>R3's Face Sheet dated 10/23/25, indicated R3 had | F0656 | Continued from page 6<br>potential to be affected by deficient practice. Therefore, the facility SW completed an audit of all residents' care plans to revise care plans to include vulnerabilities for residents susceptible to abuse and neglect. If resident is found to be affected care plan will be updated accordingly.<br><br>What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur?<br><br>To ensure deficient practice will not recur, the DNS or designee will provide education for all licensed nurses and Social Worker on updating Care Plans to include resident specific vulnerabilities, including risk of abuse. Education will be completed by 5/29/26 or prior to next working shift.<br><br>How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?<br><br>To monitor performance and ensure ongoing compliance, the DNS or designee will audit 5 random care plans to ensure the risk of vulnerabilities is in place as per MNVAA, weekly x4, monthly x3. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the DNS or designee and continued until the facility demonstrates sustained compliance as determined by the committee.<br><br>What is the date of completion?<br><br>5/29/26 | 05/29/2026 |

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| F0656 SS = D | Continued from page 7<br>dementia, disorientation, and Alzheimer's Disease.<br><br>R3's MVAA dated 4/8/26, indicated R3 was unable to report abuse/ neglect concerns, defend self from verbal/physical attacks, and manage financial affairs.<br><br>R3's care plan dated 4/29/26, did not identify or include the following vulnerability findings for R3: unable to report abuse/ neglect concerns, defend self from verbal/physical attacks, and manage financial affairs.<br><br>During an interview on 4/23/26 at 12:30 p.m., nursing assistant (NA)-A stated she would look at the resident care plan or Kardex for needs a resident might have and how to meet those needs.<br><br>During an interview on 4/23/26 at 1:23 p.m., NA-B stated on 4/11/26 around 10:00 p.m., she went into R1's room and found R2 in his wheelchair on the right side of R1's bed, with R1 lying in bed with R1's pants down and brief to the side. R2 was touching R1's vaginal area with his left hand. R1 had her eyes closed but R1's eyebrows were scrunched together. NA-B stated she was surprised by this observation. NA-B stated she left R1 and R2 in the room to get the nurse. NA-B did not stop the interaction. NA-B stated she would look in a resident care plan or Kardex for any resident needs or interventions.<br><br>During an interview on 4/29/26 at 1:45 p.m., Social Services (SS)-A stated she would complete the MVAA and once complete she would address the findings in the care plan. SS-A stated there was nothing in the care plan about vulnerabilities specifically because it was assumed everyone was a vulnerable adult and the facility treated all residents as such.<br><br>During an interview on 4/29/26 at 3:42 p.m., director of nursing (DON) stated SS-A would be responsible for completing the MVAA. All vulnerabilities should be care planned.<br><br>The facility Comprehensive Care Plan policy revised 12/29/25, indicated the facility would develop a person-centered care plan that would meet the residents physical, mental, spiritual, and psychosocial well-being. | F0656 | | 05/29/2026 |

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| 20000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On 4/22/26 through 4/29/26, 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.<br><br>The following complaints were reviewed during the survey. No licensing orders were written.<br><br>H55491313C (2983235)<br><br>H55499561C (2964767) | 20000 | | 05/21/2026 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| 20000 | Continued from page 1<br>H55494900C (2729295)<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.<br><br>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 | | 05/21/2026 |