Electronically delivered
March 5, 2025

Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

RE: CCN: 245549
Cycle Start Date: February 12, 2025

Dear Administrator:

On February 12, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J),

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).

REMOVAL OF IMMEDIATE JEOPARDY

On February 6, 2025, the situation of immediate jeopardy to potential health and safety cited at F684 was removed.

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 listed below to the CMS location.

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

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

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 February 12, 2025. 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 location may notify you of their determination regarding any imposed remedies.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - Mountain Lake is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 12, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health

Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING _____ B. WING _____	C 02/12/2025

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F 000	INITIAL COMMENTS On 2/7/25, 2/11/25, and 2/12/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed H55496786C (MN00110460) and a deficiency was issued at F684 at PAST NON-COMPLIANCE. and H55496784C (MN00110422) with NO deficiencies. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		

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

Electronically Signed

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

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F 684	Continued From page 1 by: Based on observation, interview, and document review the facility failed properly assess and monitor blood sugars, failed to identify signs and symptoms of hyperglycemia, and failed to follow continuous glucose monitor (CGM) manufacturer recommendations for placement and rechecking blood sugars for 1 of 4 residents (R1) who was admitted to intensive care unit with a blood sugar of over 1000 mg/dl (milligrams/deciliter). This resulted in an immediate jeopardy (IJ) for R1. The IJ began on 1/29/25, when R1 was demonstrating symptoms of hyperglycemia but R1's blood sugar according to the CGM was 52 mg/dl and was administered glucose tablets without confirming blood sugar via finger stick. The administrator, director of nursing (DON) and regional nurse consultant (RNC) were notified of the IJ on 2/12/25 at 4:00 p.m. The IJ was removed and the deficient practice was corrected on 2/6/25, prior to the start of the survey, and was therefore issued at past non-compliance (PNC). Findings include: The American Diabetes Association defines low blood glucose (sugar) as when levels fall below 70 mg/dL (milligrams per deciliter) and recommends using the rule of 15 grams fast-acting carbs every 15 minutes to treat low blood glucose. Severe low blood glucose is an emergency. The American Diabetes Association identifies blood sugars should be less than 180 mg/dl 1-2 hours after a meal. Further informing hyperglycemia can be a serious problem and important to treat as it is detected. If	F 684	Past noncompliance: no plan of correction required.	

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F 684	Continued From page 2	F 684		

hyperglycemia is not treated ketoacidosis, a life threatening condition, could occur. Symptoms of ketoacidosis includes shortness of breath, breath that smells fruity, nausea and vomiting, and very dry mouth. According to Mayo Clinic additional symptoms can be excessive thirst, being tired, and confusion. Mayo Clinic recommends to seek emergency care if sugar level is over 300 mg/dl.

Review of R1's quarterly Minimum Data Set (MDS) dated 1/30/25, indicated diagnosis of diabetes type 1. R1 had moderately impaired cognition and received insulin.

Review of R1's physician orders, included the following:
-apply and change Free Style Libre 3 (CGM) every 15 days, start date 11/15/24;
-blood sugar checks four times daily with CGM, before meals and at bedtime, start date 11/15/24;
-Glucagon emergency kit 1 milligram (mg) inject SQ for low blood sugars, start date 11/05/24;
-glucose oral tablets 4 gram (GM), give four tablets by mouth as needed for low blood sugar of 51-70; start date 2/28/24.

Facility policy Hypoglycemic Incidents dated 10/30/24, directed the following:
2. For residents with diabetes, the physician should be called immediately when blood glucose value is less than 70 mg/dl and is unresponsive or has consecutive blood glucose reading less than 70 mg/dl.
4b. Notify physician.
4c. monitoring may need to take place for several hours to days.
7. Document incident and actions taken in progress note health status and document the blood glucose testing in the weights and vitals

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F 684	Continued From page 3 tab. Free Style Libre 3 manufacturer's recommendations dated 4/24, included CGM's could replace blood glucose monitoring (BGM) except in the following situations. These are times when you need to do a blood glucose test before deciding what to do or what treatment decision to make as sensor readings may not accurately reflect blood glucose levels: 1- do a BGM if you think your glucose readings are not correct or do not match how you feel. Do not ignore symptoms that may be due to low or high blood sugars. 2- do a blood glucose test when you see the magnifying glass with a drop of blood symbol or when the sensor glucose reading does not include a current glucose number. R1's diabetic care plan dated 2/28/24, did not address R1's CGM. The care plan included R1 had history of hospitalizations related to fragile diabetic condition with the following interventions: -identify areas of difficulty in resident diabetic management. Provide and document teaching to resident/family to address identified roadblocks to good diabetes management, start date 2/28/24. R1's January 2025 medication administration record (MAR) identified R1's CGM was changed on 1/26/25, by LPN-H. During interview 2/12/25 at 9:25 a.m., LPN-H stated she had personal experience with CGM but no formal training. Review of R1's blood sugar records in conjunction with progress notes between 1/29/25 through 2/3/25 identified although R1's CGM	F 684		

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F 684	Continued From page 4 showed blood sugars below 70 mg/dl, no finger sticks were done to confirm the values of CGM displayed values, the record did not include comprehensive assessments and monitoring for hypo/hyperglycemia, nor include monitoring of the effectiveness of the glucose tabs after administration. Further, it was not evident the physician was notified when R1's blood sugars were low. R1's blood sugars for 1/29/25, included the following: -Blood sugar (BS) record at 4:20 a.m., identified R1 had BS of 44 mg/dl; R1's record did not include any further documentation. -BS record at 5:00 a.m., identified R1 had BS of 54 mg/dl; R1's record did not include any further documentation. -BS record at 5:40 a.m., identified R1 had BS of 60 mg/dl. Corresponding progress note documented at 10:31 a.m. identified staff were alerted by the CGM beeping and R1 was given a snack. -BS record at 8:10 a.m. identified R1 had a BS of 248 mg/dl. Progress notes at 9:52 a.m. indicated R1's insulins were held because R1 did not eat breakfast. -BS record at 12:54 p..M., identified R1 had a BS of 199 mg/dl; -BS record at 3:54 p.m. identified R1 had a BS of 262 mg/dl; -BS record at 8:23 pm. identified R1 had a BS of 305 mg/dl. Progress note identified R1 received 2 units of sliding scale insulin. R1's blood sugar record for 1/30/25, included the following: -BS record at 12:00 a.m., identified R1 had BS of 45 mg/dl. The BS record identified the next check	F 684		

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F 684	Continued From page 5 at 1:15 a.m., R1's BS was 52 mg/dl. Corresponding progress note written at 1:35 a.m. indicated at 11:55 p.m. staff alerted by R1's CGM beeping with a reading of "Lo" (no value was given). Staff administered 8 oz of high calorie/high protein drink. Rechecked blood sugar at 12:00 a.m. and was 45. Staff gave a ½ of peanut butter sandwich and 6 oz of grape juice and 8 oz of orange juice. Blood sugar recheck at 1:15 a.m. (1.25 hours later) was 52. R1 ate the sandwich but required much prompting/cuing/encouragement. -BS record at 4:00 a.m., identified R1 had a BS of 279 mg/dl; -BS record at 8:46 am and 9:15 a.m.; identified R1 had a BS of 218 mg/dl; -BS record at 11:16 a.m. was 89 mg/dl; identified R1 had a BS of 89 mg/dl; -BS record at 2:04 p.m. was 89 mg/dl; the medication administration record indicated R1's insulin was held, with no other information in the record. -BS record at 4:33 p.m., identified R1 had a BS of 199 mg/dl; -BS record at 7:48 p.m., identified R1 had a BS of 124 mg/dl. R1's BS record for 1/31/25, included the following: -BS record at 2:50 a.m., identified R1 had a BS of 60 mg/dl; -BS record at 2:53 a.m., identified R1 had a BS of 52 mg/dl; R1's progress note at 4:08 a.m. indicated R1's CGM read "Lo", R1 was administered 4 glucose tablets (16 G total) along with glucose control drink, pudding, and small cup cake. -BS record at 4:15 a.m., identified R1 had a BS of 109 mg/dl.	F 684		

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F 684	Continued From page 6 -BS record at 11:55 p.m., identified R1 had a BS of 54 mg/dl. R1 shift summary for 1/31/25 at 6:26 a.m., summarized R1's CGM was alarming during the night. BS was 60. Prior to entering room, BS had dropped to 52. Staff got glass Boost Glucose Control and pudding which resident ate. BS recheck was 79, but later staff heard the CGM alarm again, and CGM reading was "Lo". R1 was given 4 glucose tablets and wanted a cookie but not available. R1 ate a cupcake. BS recheck was 109. R1's blood sugars for 2/1/25, included the following: -BS record at 2:20 a.m., identified R1 had a BS of 53 mg/dl; corresponding progress note at 2:19 a.m. included R1 received four glucose 4 GM tablets for reading of 53 mg/dl. -BS record at 2:55 a.m., identified R1 had BS of 61 mg/dl; no further information documented. -Progress note at 4:21 a.m. indicated glucose tablets were effective. No other information documented. -BS record at 5:42 a.m. R1 had a BS of 283 mg/dl; no further information documented. -BS record at 12:47 p.m., R1 had a BS of 52 mg/dl; Progress note at 12:57 p.m. included R1's CGM was beeping with a reading of 53. Staff gave R1 4 oz orange juice, ¼ peanut butter sandwich and 4 oz sugar free vanilla and yogurt. -BS record at 1:30 p.m., 83 mg/dl. No further information was documented. R1's blood sugars for 2/2/25, included the following: -BS record at 2:55 a.m. R1 had BS of 53 mg/dl; Progress note at 3:00 a.m. indicated R1 received	F 684		

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F 684	Continued From page 7 four glucose 4 gm tablet for a reading of 53. -Progress note at 4:30 a.m. indicated the glucose tablets were ineffective. R1's record did not identify R1's BS level was prior to the administration of the second dose of four glucose tabs. No further information was documented. 2/2/25 6:31 a.m. 64 mg/dl; Progress note at 6:30 a.m. indicated the glucose tabs were effective even though the record identified a BS of 64 mg/dl. R1's BS throughout the the day, ranged from 180 mg/dl at 11:15 a.m. to 145 mg/dl at 10:55 p.m. R1's progress notes on 2/2/25 at 7:14 p.m., indicated R1 was sleepy, needing more queuing for activities of daily living (ADL's). Insulin held due to history of declining rapidly throughout the night. R1's progress notes on 2/2/25 at 9:02 p.m., indicated R1 appeared more confused than normal. Very sleepy through the afternoon. Only ate 1/2 her supper and then went back to her room, where she was asking staff about what she should do next. R1 was half undressed and wanted to get dressed for supper. Staff reminded R1 that she just finished supper and assisted R1 into her nightwear. BS monitored through shift were within range. Review of R1's BS record on 2/3/25 indicated the following: -BS record at 3:35 a.m., indicated R1 had a BS of 190 mg/dl; -BS record at 7:39 a.m., indicated R1 had a BS of 134 mg/dl. R1's progress notes on 2/3/25 at 9:10 a.m., R1 stated she was not feeling well, "I feel icky, like I was going to throw up when I saw	F 684		

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food.". Did not eat well for breakfast. Insulin held for this reason. Taking sips of lemon/lime soda. CGM is 154 mg/dl.
-BS record at 11:22 a.m., indicated R1 had a BS of 108 mg/dl; and
-BS record at 4:10 p.m., indicated R1 had a BS of 120 mg/dl.

R1's progress notes on 2/3/35 at 1:24 p.m., indicated NP-A was notified and orders were received.

R1's progress notes on 2/3/25 at 7:53 p.m., indicated R1 was sent to the emergency room for evaluation via family vehicle.

R1's progress notes on 2/3/25 at 9:18 p.m., indicated that at 5:00 p.m., BS CGM was reading 67 mg/dl. R1 was given orange juice but needed assistance with drinking it without spilling as R1 was lethargic and unable to hold drink without spilling. Staff checked a manual blood sugar and it read "Hi". Staff had another staff nurse re-check manual BS on other hand and read "Hi" again. Called on call physician at 5:50 p.m., left message for return call. At 5:55 p.m. attempted to call first family contact, message left. At 6:10 p.m., contacted second family contact and updated on R1's condition. At undocumented time, on call physician called back and wanted R1 to go to ED for evaluation. Family transferred R1 via private vehicle at 7:00 p.m. Staff called ED at 9:00 p.m. and was told that R1 was very ill with blood sugars greater than 1,000 mg/dl and was being transferred to a ICU for further care.

Review of R1's hospital records from 2/3/35 through 2/11/25, indicated R1 presented to the

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F 684	Continued From page 9 emergency department via private vehicle from skilled nursing facility (SNF) with abnormal sugars. Family reported R1 had increased confusion and somnolence over the past 2-3 days. R1's mucus membranes were dry, appeared listless and her speech was delayed and slow. Initial impression was diabetic ketoacidosis (DKA) with insulin drip (medication given through vein to help lower sugar) and fluid resuscitation started. R1 was transferred and admitted to a hospital intensive care unit (ICU) from emergency department on 2/4/25 with a BS of 1245 mg/dl. R1 was in the ICU until 2/6/25 and was transferred to the medical floor. Review of R1 medication administration record (MAR) indicated R1 received her scheduled doses of long acting insulin twice on 2/1/25 and doses were held on 2/2/25 and am of 2/3/25. R1 received sliding scale short acting at 8:30 a.m. and 6:30 p.m. on 2/1/25 and other doses were held 2/2/25 and 2/3/25. During an interview on 2/11/25 at 7:15 p.m., emergency room registered nurse (RN-G) stated on 2/3/25, R1 presented to the emergency department (ED), very lethargic and incoherent. RN-G stated she had not received a report from the nursing home, and the family stated R1 had not been feeling good the past couple of days with lower blood glucose. RN-G checked finger stick with ED meter and read "Hi". R1's ED lab work showed a BS of 1245 mg/dl. RN-G was told to remove the CGM from R1's left arm. When she did this RN-G stated the site was infected with a thick tannish fluid leaking from the site. RN-H cleaned to site. During an interview on 2/11/25 at 8:15 p.m.,	F 684		

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	245549	A. BUILDING _____ B. WING _____	C 02/12/2025

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F 684	Continued From page 10 emergency room nurse RN-H stated she has been trained in putting on CGM's and R1's CGM was located almost on her shoulder over a bone. CGM needed to be in the fleshy part of the back of the arm. RN-H further stated that when the sensor was removed, the site had a thick gray/tan drainage from the site. This drainage was foul smelling. The area was reddened and raised to the size of a quarter. During interview on 2/12/25 at 10:08 a.m. licensed practical nurse (LPN)-B indicated R1 was a fragile diabetic with blood sugars swinging from high to low and had a CGM. LPN-B stated she worked day shift on 2/3/24. R1 had complained of nausea, she had fatigue, did not want to eat, and demonstrated confusion. LPN-B explained since R1's blood sugars per the CGM had low readings, she did not identify R1's symptoms as hyperglycemic and did not confirm the meter readings with a finger stick. LPN-B indicated at the time she was not aware of the manufacturer's recommendations to follow-up with a finger stick if the meter was reading "Lo" or "Hi" so a finger sticks were not performed. During an interview on 2/12/25 at 10:40 a.m., LPN-G stated she worked the evening shift on 2/3/25. R1 was more confused than usual at start of shift. At 5:00 p.m., LPN-G responded to R1's CGM beeping with a reading of 67. LPN-G followed the protocol for low blood sugars and gave R1 orange juice and glucose tabs. LPN-G stayed with R1 and rechecked her blood sugar an undocumented amount of times, but the CGM kept reading that R1's blood sugar was going down. LPN-G then did a couple of finger sticks which resulted in "Hi" readings from that meter. LPN-G then called and left a message for the	F 684		

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F 684	Continued From page 11 on-call physician who replied 30-minutes later with an order to send R1 to the emergency room. R1 left facility at 7:00 p.m. per private vehicle. On 2/3/25, LPN-G was not aware of the manufacturer's recommendation to confirm the blood sugars with the finger stick method after each "Lo" reading so LPN-G did not confirm blood sugars via finger stick nor aware when the physician should be notified when residents had low blood sugars. During an interview on 2/12/25 at 10:51 a.m., LPN-F stated prior to 2/3/23 he had not received education on CGM's. LPN-F would have given nutritional supplements or glucose tabs based on the CGM readings, would not have confirmed with a finger stick and/or symptoms. LPN-F also indicated he was not aware prior to 2/3/25, when to notify the physician if residents required administration of glucose tabs or Glucagon. During an interview on 2/12/25 at 11:30 a.m., nurse practitioner (NP) stated she saw R1 on 2/3/25 but was not made aware of R1's low blood sugars or holding of R1's insulin doses on 2/1/25 and 2/2/25. NP-A stated her expectation was that facility would contact her with readings on CGM out of the parameters of, less than 60 or greater than 400. NP further expected the facility staff perform a finger stick BGM to verify the reading During an interview on 2/12/25 at 12:50 p.m., director of nursing (DON) stated she had reviewed a slide deck about how to use and placement of Freestyle Libre system on 1/28/25. It was her expectation that anyone who ever did not come to the meeting, would read the PowerPoint at the nurses station and then sign that they have read it. On 2/6/25, DON has	F 684		

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F 684	Continued From page 12 placed notes on medication carts to check a finger stick per manufacture recommendations with blood sugars below recommendation of 70 or if resident was showing signs of symptoms of hypo/hyper glycemia. It was her expectation that staff would report to provider anything under 60 or higher than 400, unless the provider has a different parameter. Expectation to re-check BS, normally would be 5 minutes. During an interview on 2/12/25 at 9:11 a,a.m., customer service representative (CS-B) stated the sensor should be applied to the back of the upper arms and remains for 14 days. After 14 days the sensor shuts off and will no long give a reading. The sensor will not read a correct reading, if not placed in the recommended placement on back of either upper arm. If the sensor was applied a little bit high or low it should not be affect the reading. If the site becomes infected at the site of insertion, or if the site bleeds, both may affect the readings. Manufacturer further recommends if there is pain at the insertion site, the customer takes the sensor off and applies a new one. The high and lows alarms are set up with default parameters of 70 and 250. The extreme low is mandatory by law and can not be turned off by law. Review of facility policy Blood glucose monitoring, disinfecting, and cleaning policy dated 9/25/24, did not indicate the use of CGM's for blood sugar monitoring. The PNC IJ began on 1/29/25. The immediate Jeopardy was removed, and the deficient practice corrected on 2/6/25 after the facility implemented the following prior to start of survey: -Review policy on blood sugar monitoring to	F 684		

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F 684	Continued From page 13 include the use of CGM's and management of CGM's per manufacturer's recommendations -Educated staff on correct placement of CGM's that the facility uses -Educated staff on the signs and symptoms of hyper- and hypo- glycemia -Educated staff on when to do a finger stick BGM to verify the CGM's readings -Reviewed with staff when to alert the physician of low and high blood sugars.	F 684		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 5, 2025

Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

Re: Event ID: 7MW111

Dear Administrator:

The above facility survey was completed on February 12, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00755	A. BUILDING: _____ B. WING _____	C 02/12/2025

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/7/25, 2/11/25, and 2/12/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H55496786C (MN00110460) and H55496784C	2 000		

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2 000	Continued From page 1 (MN00110422) . NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		