



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 11, 2025

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

RE: CCN: 245568
Cycle Start Date: December 27, 2024

Dear Administrator:

On February 4, 2025, we notified you a remedy was imposed. On March 9, 2025 the Minnesota Departments of Health and Public Safety 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 February 14, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 27, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 4, 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 27, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 14, 2025, 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 Therefore, the NATCEP prohibition is rescinded.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



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March 11, 2025

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

Re: Reinspection Results
Event ID: B3U812

Dear Administrator:

On February 20, 2025 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 27, 2024. 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
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 14, 2025

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

RE: CCN: 245568
Cycle Start Date: December 27, 2024

Dear Administrator:

On December 27, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Terri Ament, Regional Operations Supervisor, Rapid Response

Health Regulation Division

Minnesota Department of Health

Duluth Technology Village

11 East Superior Street, Suite 290

Duluth, Minnesota 55802-2007

Email: teresa.ament@state.mn.us

Office: (218) 302-6151 Mobile: (218) 766-2720

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 27, 2025 (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 27, 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

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>

Good Samaritan Society - Mary Jane Brown

January 14, 2025

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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,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a loop at the end of the last name.

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



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January 14, 2025

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

Re: State Nursing Home Licensing Orders
Event ID: B3U811

Dear Administrator:

The above facility was surveyed on December 26, 2024 through December 27, 2024 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. 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.

Good Samaritan Society - Mary Jane Brown

January 14, 2025

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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:

Terri Ament, Regional Operations Supervisor, Rapid Response

Health Regulation Division

Minnesota Department of Health

Duluth Technology Village

11 East Superior Street, Suite 290

Duluth, Minnesota 55802-2007

Email: teresa.ament@state.mn.us

Office: (218) 302-6151 Mobile: (218) 766-2720

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

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245568	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/27/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MARY JANE BROWN			STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(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	
F 000	INITIAL COMMENTS On 12/26/24 and 12/27/24, 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. The following complaint was reviewed: H55683380C (MN00109337) with an incidental finding cited at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		12/30/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/27/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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 880	<p>Continued From page 1</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p>	F 880		

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F 880	<p>Continued From page 2</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to utilize enhanced barrier precautions (EBP) for 1 of 3 residents observed for infection prevention.</p> <p>Findings include:</p> <p>R3's significant change Minimum Data Set (MDS) dated 12/16/24 indicated R3 had intact cognition with diagnoses including stroke, diabetes, and depression.</p> <p>R3's care plan dated 12/4/24 indicated R3 required EBP related to indwelling medical devices: urinary catheter and feeding tube. R3's care plan instructs to don (put on) gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene, changing linens, repositioning, checking and changing, device care and/or use, and wound care.</p> <p>On 12/27/24 at 11:17 a.m., registered nurse (RN)-A and nursing assistant (NA)-A were observed entering R3's room with a full</p>	F 880	<p>Immediate education was provided to RN-A and NA-A on 12/27/24 regarding proper (EBP) enhanced barrier precautions. Education was provided by Infection Preventionist. No adverse effects noted to resident.</p> <p>All resident using EBP have the potential to be effected by this deficient practice. Infection Preventionist reviewed all residents using EBP, for PPE supplies, signage, and proper use by 12/30/24.</p> <p>To ensure reoccurrence does not occur, facility initiated EBP focused audits (details). Education was provided to all nursing staff regarding EBP use, starting on 12/27/24 and was completed prior to next oncoming shift. EBP online training course was assigned to all nursing home staff. This is correct and was done confirmed with Marie, I attached the documents as well.</p> <p>To monitor ongoing progress DNS or</p>	

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F 880	<p>Continued From page 3</p> <p>mechanical lift. A magnet on the doorframe of the room indicated enhanced barrier precautions were required for high contact resident care activities including transferring. Neither RN-A or NA-A were observed to don a gown or gloves. Staff RN-A and NA-A were observed to transfer R3 from her wheelchair to the recliner with out wearing a gown or gloves. RN-A connected tubing from a feeding pump to the feeding tube on R3's abdomen.</p> <p>On 12/27/24 at 11:27 a.m., R3 stated staff wear a gown and gloves when they change her, but not when transferring from wheelchair to recliner.</p> <p>On 12/27/24 at 11:43 a.m., NA-A stated EBP should be worn when dressing a resident, providing catheter care or changing a resident's brief, but does not need to be worn when transferring a resident. She acknowledged she did not wear a gown when assisting with the transfer of R3.</p> <p>On 12/27/24 at 11:49 a.m., RN-A stated EBP needed to be utilized when dealing with whatever the resident is on EBP for, like catheters, wound care, and feeding tubes. EBP should also be worn when providing cares but did not need to be worn for transfers. She acknowledged she did not wear a gown when she assisted with the transfer or when attaching tubing to R3's feeding tube. She confirmed a gown and gloves should have been worn while working with R3's feeding tube.</p> <p>On 12/27/24 at 1:16 p.m., medical doctor (MD)-A stated lack of utilization of EBP could spread infections to other residents. Residents may be colonized (bacteria in the body without active infection) with bacteria the staff are unaware of.</p>	F 880	designee will audit by observation resident who are using EBP weekly x2, monthly x4. Findings will be brought to QAPI committee for further recommendations and review.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 880	<p>Continued From page 4</p> <p>Residents with urinary catheters and indwelling medical devices have an increased risk of infection.</p> <p>On 12/27/24 at 1:46 p.m., RN-B stated EBP should be worn any time staff have direct contact with the resident or are working with something that is soiled. Examples of when EPB should be worn include caring for catheters or feeding tubes and during all transfers. EBP is worn to prevent spreading infection between residents. RN-B confirmed R3 requires EBP related to a feeding tube and urinary catheter. Residents who require EBP will have a magnet on the doorframe of their room.</p> <p>The Standard and Transmission-Based Precautions policy dated 4/2/24 informs EBP expand the use of PPE (personal protective equipment) beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of multi-drug resistant organisms to staff hands and clothing. High contact resident care activities include: transfers, urinary catheter care or use, and feeding tube care or use.</p>	F 880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00575	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MARY JANE BF	STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LIVERNE, MN 56156
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2 000	<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: On 12/26/24 and 12/27/24, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 01/27/25
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00575	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MARY JANE BF	STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LIVERNE, MN 56156
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(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) COMPLETE DATE
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2 000	<p>Continued From page 1</p> <p>and identify the date when they will be completed.</p> <p>The following complaint was reviewed: H55683380C (MN00109337) with an incidental finding issued at 4658.0800 Subp. 1 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.</p> <p>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/ib14_1.html> 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.</p>	2 000		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00575	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
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2 000	Continued From page 2 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.	2 000		
21375	<p>MN Rule 4658.0800 Subp. 1 Infection Control; Program</p> <p>Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to utilize enhanced barrier precautions (EBP) for 1 of 3 residents observed for infection prevention.</p> <p>Findings include:</p> <p>R3's significant change Minimum Data Set (MDS) dated 12/16/24 indicated R3 had intact cognition with diagnoses including stroke, diabetes, and depression.</p> <p>R3's care plan dated 12/4/24 indicated R3 required EBP related to indwelling medical devices: urinary catheter and feeding tube. R3's care plan instructs to don (put on) gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene, changing linens, repositioning, checking and changing, device care and/or use, and wound care.</p>	21375	<p>Immediate education was provided to RN-A and NA-A on 12/27/24 regarding proper (EBP) enhanced barrier precautions. Education was provided by Infection Preventionist. No adverse effects noted to resident.</p> <p>All resident using EBP have the potential to be effected by this deficient practice. Infection Preventionist reviewed all residents using EBP, for PPE supplies, signage, and proper use by 12/30/24.</p> <p>To ensure reoccurrence does not occur, facility initiated EBP focused audits (details). Education was provided to all nursing staff regarding EBP use, starting on 12/27/24 and was completed prior to next oncoming shift. EBP online training course was assigned to all nursing home staff. This is correct and was done</p>	12/30/24

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21375	<p>Continued From page 3</p> <p>On 12/27/24 at 11:17 a.m., registered nurse (RN)-A and nursing assistant (NA)-A were observed entering R3's room with a full mechanical lift. A magnet on the doorframe of the room indicated enhanced barrier precautions were required for high contact resident care activities including transferring. Neither RN-A or NA-A were observed to don a gown or gloves. Staff RN-A and NA-A were observed to transfer R3 from her wheelchair to the recliner with out wearing a gown or gloves. RN-A connected tubing from a feeding pump to the feeding tube on R3's abdomen.</p> <p>On 12/27/24 at 11:27 a.m., R3 stated staff wear a gown and gloves when they change her, but not when transferring from wheelchair to recliner.</p> <p>On 12/27/24 at 11:43 a.m., NA-A stated EBP should be worn when dressing a resident, providing catheter care or changing a resident's brief, but does not need to be worn when transferring a resident. She acknowledged she did not wear a gown when assisting with the transfer of R3.</p> <p>On 12/27/24 at 11:49 a.m., RN-A stated EBP needed to be utilized when dealing with whatever the resident is on EBP for, like catheters, wound care, and feeding tubes. EBP should also be worn when providing cares but did not need to be worn for transfers. She acknowledged she did not wear a gown when she assisted with the transfer or when attaching tubing to R3's feeding tube. She confirmed a gown and gloves should have been worn while working with R3's feeding tube.</p> <p>On 12/27/24 at 1:16 p.m., medical doctor (MD)-A stated lack of utilization of EBP could spread</p>	21375	<p>confirmed with Marie, I attached the documents as well.</p> <p>To monitor ongoing progress DNS or designee will audit by observation resident who are using EBP weekly x2, monthly x4. Findings will be brought to QAPI committee for further recommendations and review.</p>	
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21375	<p>Continued From page 4</p> <p>infections to other residents. Residents may be colonized (bacteria in the body without active infection) with bacteria the staff are unaware of. Residents with urinary catheters and indwelling medical devices have an increased risk of infection.</p> <p>On 12/27/24 at 1:46 p.m., RN-B stated EBP should be worn any time staff have direct contact with the resident or are working with something that is soiled. Examples of when EPB should be worn include caring for catheters or feeding tubes and during all transfers. EBP is worn to prevent spreading infection between residents. RN-B confirmed R3 requires EBP related to a feeding tube and urinary catheter. Residents who require EBP will have a magnet on the doorframe of their room.</p> <p>The Standard and Transmission-Based Precautions policy dated 4/2/24 informs EBP expand the use of PPE (personal protective equipment) beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of multi-drug resistant organisms to staff hands and clothing. High contact resident care activities include: transfers, urinary catheter care or use, and feeding tube care or use.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies and procedures on infection control and EBP. The DON or designee could educate all staff on these policies and procedures. The DON or designee could audit to ensure all staff members are appropriately utilizing EBP and report these findings to the QAPI committee.</p>	21375		
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21375	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty one (21) days	21375		