STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Stillwater	1119 Owens Street North Stillwater, MN 55082

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure liquid morphine (opioid analgesic used to treat severe pain) was administered per physician orders for 1 of 1 resident (R1) who was administered ten times the ordered dose.Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated diagnosis of anemia, heart failure, diabetes mellitus, and seizure disorder. The MDS indicated she was moderate cognitively intact and required assistance with activities of daily living. The MDS indicated R1 received scheduled pain medication and had a condition or chronic disease that may result in life expectancy of less than 6 months and received hospice care.R1's Care Plan dated 10/13/25, indicated R1 had acute and chronic pain/discomfort related to history of cerebral vascular accident and weakness. The care plan indicated nursing to evaluate the effectiveness of pain interventions after administration of pain medication, satisfaction with results, impact on functional ability and impact on cognition. The Care Plan further indicated R1 had terminal prognosis related to acute on chronic heart failure and was on hospice. R1's Physicians Orders dated 10/1025 indicated morphine sulfate (concentrate) oral solution 20 milligrams (mg)/ milliliters (ml), give 0.75 ml one hour as needed for pain or dyspnea.R1's Medication Administration Record (MAR) indicated on 10/10/25 R1 received 0.75 ml on 6:53 a.m. and 9:02 a.m. The order was increased to give 20mg/ml, give 1 ml as needed every one hour as needed for pain or dyspnea on 10/10/25, the MAR indicated this dose was never given.A Hospice Client -New Orders dated 10/10/25, ordered from hospice physician (over the phone) and transcribed by hospice nurse, registered nurse (HRN)-A to discontinue morphine 20mg/ml to give 1ml every one hour as needed (PRN). Begin morphine 20 mg(ml) give 15mg/7.5 ml oral/ sublingual every four hours for restlessness, and morphine 20 mg/ml may have 15 mg/7.5 ml every one hour for dyspnea or pain. (This went from the 0.75 ml dose R1 received to 7.5 ml which is ten times the dosage and transcribed incorrectly) The MAR indicated on 10/10/25 at 12:00 p.m., R1 received 7.5 ml of Morphine Sulfate concentrate for pain level of four.R1's MAR indicated she received Narcan 4 mg, also known as Naloxone (naloxone, a front-line defense in the nation's overdose crisis. Naloxone is a life-saving drug that, when sprayed into the nose or injected, quickly reverses the powerful effects of opioids during an overdose) on 10/10/25, at 9:18 p.m. and 10:53 p.m. with all doses listed as effective.A Provider follow up Note Progress Note dated 10/10/25, indicated R1 presented with hypertensive heart disease with chronic diastolic heart failure, hospice care, hemiparesis, and expressive aphasia. The note indicated patient was seen multiple times today this afternoon and evening dule to medication error with administration of morphine sulfate. Extensive discussion with patient's daughter, granddaughter. Spoke with hospice staff and hospice medical director. Narcan 4 mg was administered 4:00 p.m. and as of 8:30 pm. patient has not required another dose. Respiration rate (RR) remaining above 8 and around 8:00 p.m. was 18. Director of nursing and nursing staff are monitoring patient closely and checking RR every 15-30 minutes. At 8:40 p.m. patient was seen and had been repositioned. Breathing was shallower, rate appeared to be decreasing. Discussed with DON and we opted to give another dose of Narcan 4mg. Once given patients breathing appeared to improve, she was yawning and moving her mouth more and seemed less sedated. Nursing will be monitoring closely through the night. Again, extensive discussion with family at bedside, questions addressed, concerns addressed. Daughter plans on leaving to go home around 9:00 p.m. Was informed by text message that a third dose of Narcan was given just before 10:00 p.m. due changes in respirations.A requested MAR to the DON on 11/06/25, was not received until 11/18/25, by the facility administrator which indicated the dose that was given at 10:53 p.m. was in error and that was actually given at 4:50 p.m. and received it at 9:18 p.m. (which does not match what the NP indicated in her notes R1 received three doses of Narcan)Interview on 10/29/25 at 1:16 p.m., the director of nursing (DON) stated on 10/09/25, R1 was up in her wheelchair seemed perfectly fine normally arguing with me not wanting to go to bed then on 10/10/25, in the morning when I came in around 10:00 a.m. the nursing staff told me she had a stroke. The DON stated the hospice nurse came in and evaluated R1 and felt she had cardiac or CVA (cerebral vascular accident) and increased her morphine. The hospice nurse made a medication error and instead of transcribing morphine .75 ml to be given she transcribed 7.5 ml and the at 12:00 p.m., RN-A administered morphine sulfate 7.5 ml. from an existing bottle of morphine R1 had. The DON stated the evening nurse licensed practical nurse (LPN)-A noticed the medication error when the new morphine medication arrived with the prescription label that indicated to give .75ml instead of 7.5 ml. LPN-A then informed hospice and orders for