STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Howard Lake	413 13th Avenue Howard Lake, MN 55349

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interview, the facility failed to ensure food and beverages were handled and served in a sanitary manner to prevent contamination for residents receiving meals in the dining room. Additionally, the facility failed to consistently monitor dishwasher temperatures for rinse cycles and take timely action to correct the process to assure temperatures were within the desired range for the rinse cycle for 1 of 1 dishwashers observed. This had the potential to affect all 28 current residents, as well as staff, who ate food served from dishes and tableware that were cleaned in the dishwasher. Further more, the facility failed to ensure proper measures were implemented with meal preparation to ensure food was handled and prepared for service in a sanitary manner to prevent contamination of food products. This had the potential to affect residents, guests, and staff receiving meals served from the kitchen.Findings include: During observation of the evening meal service on 02/10/26 at 4:35 p.m., dietary aide (DA)-A was observed delivering beverages to multiple residents in the dining room without wearing gloves. DA-A was observed entering and exiting the kitchen, multiple times, to obtain beverages for individual residents and was observed touching the kitchen keypad and door handle during each entry and exit DA-A was also observed touching dining room tabletops, counters, water pitchers, and the ice machine between beverage deliveries without performing hand hygiene. While carrying the beverages, DA-A was observed placing bare fingers around the rim of multiple Cook-A was observed transporting four plated meals at one time from the kitchen to the dining area without wearing gloves. Two of the plates were observed in direct contact with the cook's shirt while being carried. The plates were subsequently served to residents without being re-plated or discarded. During observation of the evening meal service on 02/11/26 at 4:37 p.m., DA-B was observed delivering beverages to multiple residents in the dining room without wearing gloves. DA-B was observed multiple times entering and exiting the kitchen to obtain beverages for individual residents and was observed touching the kitchen keypad and door handle during each entry and exit. DA-B was also observed touching dining room tabletops, counters, water pitchers, and the ice machine between beverage deliveries without performing hand hygiene. While carrying the beverages, DA-B was observed placing bare fingers around the rim of multiple drinking glasses, directly contacting the area where residents' mouths contact during consumption. The beverages were delivered directly to residents without corrective action, hand hygiene, or replacement of the glasses. During an interview on 02/10/26 at 6:26 p.m., DA-A stated she prepared beverages individually as residents arrived in the dining room and delivered the drinks to residents. DA-A stated she did not wear personal protective equipment (PPE), including gloves, when delivering beverages. DA-A confirmed her fingers contacted the rim of the drinking glasses in the area where residents' lips contact during consumption. DA-A stated gloves should be worn during beverage service due to the potential for cross-contamination when assisting multiple residents during meal service. (continued on next page)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/10/26 at 6:32 p.m., Cook-A stated he typically served meals by carrying multiple plates at one time. Cook-A confirmed he carried four plates simultaneously, with some plates resting against his shirt on his chest and stomach. The cook stated he usually wore gloves during meal service but confirmed he was not wearing gloves at the time of observation and acknowledged gloves should have been worn. During an interview on 02/12/26 at 1:30 p.m., the dietary manager (DM) stated staff did not routinely wear gloves when delivering food and beverages. The DM stated staff should not touch the tops or rims of drinking glasses due to the risk of contaminating food contact surfaces. The DM stated plates should not contact staff clothing during service due to the risk of contamination. Staff were expected to use gloves during meal service and that glove use was encouraged. Review of the facility's Hand Washing and Glove Use – Food and Nutrition Services policy, dated 06/06/25, indicated the facility provided guidelines regarding hand hygiene and glove use to reduce the risk of cross-contamination when serving highly susceptible populations. The policy indicated employees were not to touch food with bare hands and were to use proper utensils, including tissue, spatulas, tongs, or single-use gloves, when handling food. The policy further indicated employees involved in food preparation, distribution, and service were required to consistently utilize proper hygienic practices and techniques. Dishwasher On 2/9/26 at 7:11 a.m. an initial tour and interviews were completed. The dishwashing area was observed with cook-B. Cook-B stated the current dishwasher was a steam dishwasher and was temperature based, with the wash temperature to be at 150 degrees Fahrenheit (F), and rinse cycle at a temperature of 180 degrees Fahrenheit. A review of the February temperature log of both wash and rinse cycles temperatures was completed and were noted to have been consistently tracked. All temperatures were noted to be within the desired range, except for the following dates on the morning shift: 2/1/26 morning rinse cycle of 170 degrees F.; 2/4/26 morning rinse cycle of 174 degrees F.; and on 2/5/26 morning rinse cycle of 175 degrees F. Cook-B stated when she worked, she would run loads through when completing morning prep. Cook-B stated when this occurred, she would advise the dietary manager (DM)-A. Cook-B stated she had been informed to run additional racks through at that time to bring the temperatures up by DM-A. [NAME] B stated she was unaware to run racks through prior to checking the temperatures to ensure the temperature was at the desired temperature. The January temperature log was reviewed, and it was noted to have been completed on 30 of 31 days. A review of the temperature entries indicated the temperatures were within the desired temperature range for both wash and rinse cycles, with the exception of 10 of the 30 morning rinse temperatures being below 180 degrees F., with the range of those temperatures being between 170-179 degrees F. During interview on 2/12/26 at 10:18 a.m., the contracted service technician (CST)-A was working on the dishwasher. CST-A stated the temperature of the water in the rinse cycle needed to get up to 180 degrees to achieve the desired surface temp of 160 degrees F. CST-A stated a secondary test, using either a temperature strip or lollipop thermometer should be used periodically to assure the accuracy of the dishwasher thermometer. On 2/12/26 at 10:41 a.m., DM-A stated when monitoring temperatures, they had both temperature strips and the lollipop thermometer available for comparison to assure dishwashing machine (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thermometers remained accurate. DM-A stated it was important to ensure the dishwasher was at the appropriate temperature to prevent illness in residents. DM-A went on to state The high temperature is used to kill the bacteria and germs. The facility policy, titled Warewashing- [sic] Mechanical and Manual-Food and Nutrition, last reviewed 3/27/25, identified Warewashing [sic]means the cleaning and sanitization of utensils and food-contact surfaces of equipment. The policy outlines for staff the wash and rinse cycles are to be monitored and recorded on the Dish Machine Temperature Log. The policy directs staff if temperatures are outside acceptable parameters, employees notify the director of food and nutrition services (DFN) before proceeding with ware washing. The documentation provided by the Dishmachine [sic] Rental Program, provided by the facility, outlines the minimum temperature of the water for wash was 150 degrees F., and the minimum rinse cycle temperature was 180 degrees F. Meal Prep During observation and interview on 2/12/26 at 10:24 a.m., cook-C was observed during meal prep. Cook-C was observed to have hairnet/restraint in place; however, bangs were noted to be outside of the restraint of the hairnet. After washing her hands with soap and water, cook-C proceeded to set up strawberry ice cream for dessert. Cook-C removed the cover off of the large round container of strawberry ice cream. Cook-C placed a disposable glove on her right hand and picked up the ice cream scoop. Cook-C used her right hand to scoop the ice cream from the container, while resting her left hand on the edge of the ice cream container. Once the ice cream was scooped, cook-C used her ungloved hand to hold onto the dish and placed a scoop of ice cream in each dish. While securing the container of the ice cream, when the ice cream required more effort to scoop, cook-C's pointer finger was observed to slide down into the container. While scooping with the right, gloved, hand, cook-C was observed to roll the scoop up the side of the container where ungloved finger had been resting. Cook-C was observed to use a paper towel to wipe off her left hand on one occasion while scooping the ice cream. Once ice cream was served, it was covered with saran wrap and placed in the freezer. Cook-C was then observed to remove her right glove, and disposed of it into the garbage can, and wash her hands. Upon completion of task on 2/12/26 10:38 a.m., cook-C was interviewed about use of only one glove. Cook-C stated it would be preferable to wear gloves on both hands and was unsure why she had only put on one glove. Cook-C stated hairnets are used to prevent hair from going into the food served to others. Cook-C stated she normally had all hair contained in hairnet and stated hairnet seemed to ride up on me. During interview on 2/12/26 at 1:27 p.m. dietary manager (DM)-A stated when completing food preparation, gloves should be used on both hands. DM-A stated this was important for infection control. DM-A stated hairnets were important to prevent hair in food items. The facility policy, Hand Washing and Glove Use-Food Nutrition Services, last reviewed 6/6/25, identified Employees do not touch any food with bare hands – ready-to-eat or otherwise. Proper utensils such as tissue, spatula, tongs, and single-use gloves should be used for food handling to reduce the risk of cross-contamination. The facility policy, Employee Hygiene and Dress Code-Food and Nutrition Services, last reviewed/revised 5/27/25, identified Hairnets or hair restraints and beard nets or beard restraints are used: a. When cooking, preparing, assembling food or ingredients. This includes dish rooms and storage areas. See specific state guidelines. Hair is to be covered completely.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to ensure staff implemented infection prevention practices by offering assistance, encouragement, or reminders for residents to sanitize their hands prior to dining. This had the potential to affect all residents eating in the dining room.Findings include:During observation of the dining room on 02/10/2026 at 4:35 p.m., residents were seated at tables where containers of Sani-Hands hand sanitizing wipes were visibly placed in the center of each table. Residents proceeded to eat their meals without staff offering assistance, reminders, or encouragement to sanitize their hands prior to eating. No staff were observed directing residents to the hand sanitizer or assisting residents who required cues or assistance due to physical or cognitive limitations. During observation of the dining room on 02/11/2026 at 4:37 p.m., residents were seated at tables where containers of Sani-Hands hand sanitizing wipes were visibly placed in the center of each table. Residents again proceeded to eat their meals without staff offering assistance, reminders, or encouragement to sanitize their hands prior to eating. No staff were observed directing residents to the hand sanitizer or assisting residents who required cues or assistance due to physical or cognitive limitations. During interview on 02/10/2026 at 6:26 p.m., Dietary Aide (DA)-A stated the sanitizing wipes placed on dining room tables were intended to be used at every meal and residents typically sanitized their hands independently. Dining room staff or the staff who assisted residents into the dining room were responsible for assisting dependent residents with hand sanitization. DA-A did not offer reminders or provide assistance to any residents with hand sanitization during the evening meal. During interview on 02/10/2026 at 6:32 p.m., Cook-A stated the sanitizing wipes placed on dining room tables were for resident use. Independent residents were expected to sanitize their hands independently and dependent residents received staff assistance. Cook-A stated nursing assistants were expected to assist residents who required help with hand sanitization. Cook-A further stated hand sanitization should have occurred prior to the meal, as the meal primarily consisted of finger foods and residents were using their hands to eat. During interview on 02/11/2026 at 4:55 p.m., nursing assistant (NA)-B stated she did not assist any residents with hand sanitization prior to the meal. NA-B stated assisting residents with hand sanitizing was the responsibility of all staff. During interview on 02/11/2026 at 12:04 p.m., NA-A stated it was the responsibility of the staff who assisted residents into the dining room to assist residents or provide reminders to use sanitizing wipes before and after meals. During interview on 02/12/2026 at 1:30 p.m., the dietary manager (DM) stated staff were expected to encourage residents to use hand sanitizing wipes prior to meals. Hand sanitization should have occurred for infection prevention purposes, particularly when meals included finger foods. A facility infection prevention and control policy related to hand hygiene during meals was requested but was not received.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident was treated with dignity and respect during the dining experience for 1 of 1 resident (R4) reviewed for dignity. Findings include:R4's quarterly Minimum Data Set (MDS) dated [DATE] identified R4 had moderately impaired cognition and required assistance with activities of daily living (ADLs). R4's diagnoses included non-traumatic brain dysfunction (impairment of brain function affecting cognition or behavior not caused by physical injury), hypertension (chronically elevated blood pressure), urinary tract infections (infection of the urinary system), hyponatremia (abnormally low serum sodium levels), non-Alzheimer's dementia (progressive cognitive decline not attributed to Alzheimer's disease), and malnutrition (insufficient nutritional intake resulting in impaired health status). During continuous observation on 2/10/26 from 4:35 p.m. through 4:54 p.m., R4 had been assisted into the dining room by staff and had been seated at a table with two other residents. At 4:39 p.m., the tablemates had been served their meals and had begun eating; however, R4 had not received her meal at that time and had remained seated without a meal while the other residents had continued eating. At 4:48 p.m., R4 had still not received her meal and had asked the other residents, Was the food good? after they had finished eating. At 4:54 p.m., R4's meal had been delivered; however, by that time, the other residents at the table had completed their meals, resulting in R4 waiting approximately 15 minutes or longer. During interview on 2/10/26 at 6:26 p.m., dietary aide (DA)-A was unable to provide an explanation for why R4's meal was delayed while other residents at the table were served in a timely manner. DA-A stated residents were served on a first-come, first-served basis. During interview on 2/10/26 at 6:32 p.m., the cook stated he typically served residents as they entered the dining room and ensured drinks were provided. He stated he asked residents what they would like to eat and served meals as residents arrived. He further stated, once dining room activity slowed, he attempted to serve meals by table, as he did not like seeing residents waiting while others were eating. The cook confirmed R4's tablemates had been served their meals and R4 was the last resident seated at that table. He further confirmed he forgot to serve R4's meal initially and did not realize R4 had not received her meal until later. He stated R4 had been sitting without a meal for quite awhile before her meal was delivered. During interview on 2/11/26 at 10:59 a.m., R4 stated watching other residents eat while she waited for her meal made her feel increasingly hungry and caused her to sit wondering when her meal would be served. The facility Dining Service Standards policy, dated 12/18/25, indicated the facility would provide assistance with dining in a manner that promoted independence, maintained dignity, and focused on quality of life. The facility Resident Dignity policy, dated 12/18/25, indicated the facility would promote care for residents in a manner and environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the resident's physician was notified of change in condition and significant clinical events in accordance with provider orders for 1 of 1 resident (R20) reviewed for change in condition. Findings include: R20's admission Minimum Data Set (MDS) dated [DATE], identified R20 had intact cognition and required assistance with activities of daily living (ADLs). R20's diagnoses included acute on chronic combined systolic and diastolic heart failure (a condition in which the heart experienced both acute worsening and long-standing impairment of its ability to pump and fill effectively), coronary artery disease (narrowing or blockage of the coronary arteries supplying blood to the heart), heart failure (a chronic condition in which the heart was unable to pump sufficient blood to meet the body's needs), gastroesophageal reflux disease (GERD) (backflow of stomach contents into the esophagus causing irritation and discomfort), hyperlipidemia (elevated levels of fats or cholesterol in the blood), lymphedema (chronic swelling caused by impaired lymphatic drainage), fluid overload (excess fluid in the body with the potential to worsen cardiac and respiratory status), history of falling (previous episodes of loss of balance resulting in falls), edema (swelling caused by excess fluid in body tissues), hypokalemia (abnormally low potassium levels in the blood with the potential to affect heart rhythm and muscle function), and morbid obesity (excessive body weight associated with increased risk of serious health conditions). R20's physician orders printed on 2/12/26, indicated a provider order requiring staff to obtain daily weights in the morning for congestive heart failure (CHF) protocol and to notify the provider of a weight increase of three or more pounds within 24 hours or five or more pounds within one week. The physician orders also indicated a provider order for Nitroglycerin 0.4 mg sublingual (under the tongue) to be administered every five minutes as needed for chest pain or other signs or symptoms of acute angina, after the initial dose, the medication could be repeated every five minutes for up to two additional doses. If chest pain or acute angina was not relieved after three doses, staff were to contact the provider; if the provider could not be contacted, staff were to call 911 immediately unless contrary to the resident's advance directives. R20's electronic medical record (EMR) reviewed 1/1/2026 through 2/11/2026, indicated R20 experienced a weight gain greater than three pounds in one day on three separate occasions, including 1/21/26, 2/3/26, and 2/11/26. R20's nursing notes, weight logs, and physician communication records failed to include documentation the provider was notified of these weight changes as required by the provider order. R20's EMR also indicated Nitroglycerin was administered to R20 on five separate occasions, including 1/21/26, 1/23/26, 1/29/26, 2/1/26 (two doses administered 10 minutes apart), and 2/10/26. Review of the medical record, Medication Administration Records (MARs), and physician communication documentation indicated no evidence the provider was notified following Nitroglycerin administration prior to 2/10/26. During interview on 2/12/26 at 8:27 a.m., the nurse practitioner (NP) stated she expected nursing staff to follow all provider-established parameters and to notify the provider using a portal message. NP expected the message would include a nursing assessment. Staff were expected to report weight gain, lung assessment findings, and the presence of edema. While notification of weight gain depended on the resident's baseline weight and clinical presentation, in the presence of CHF and increased edema she would have considered prescribing a diuretic, as R20 had previously required diuretic medication for fluid management. NP stated the last time she had been notified of weight gain for R20 was 12/23/25. NP stated she had been notified of one dose of Nitroglycerin administered to R20 on 2/10/26; however, NP was not aware the resident had received five doses prior to that date. NP stated she should have been notified of the repeated administration of Nitroglycerin, as it was considered a higher-risk medication. Had NP been aware of the multiple doses, she would have evaluated the situation more closely, including reviewing potential contributing factors, and noted the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	timing coincided with the discontinuation of R20's Protonix (used to reduce stomach acid production). During interview on 2/12/26 at 8:56 a.m., registered nurse (RN)-A stated nursing assistants (NA)'s obtained daily weights for residents with CHF and either documented the weights in the medical record or reported them to the nurse. If weight parameters were met, nursing staff were expected to notify the provider and include recent weight trends in the notification. RN-A also stated the provider should be notified in the event of chest pain or administration of Nitroglycerin. During interview on 2/12/26 at 9:13 a.m., NP stated the provider should be notified whenever Nitroglycerin was administered. NP did not believe the weight gain resulted in harm and did not consider the event significant; however, if the provider had been notified, additional interventions or follow-up would have been implemented. During interview on 2/12/26 at 12:04 p.m., NA-A stated NA's obtained residents' weights and either provided the weights to the nurse or entered them into the EMR. During interview on 2/12/26 at 12:10 p.m., NA-B stated NA's obtained residents' weights, entered them into the EMR, and reported them to the nurse. During interview on 2/23/26 at 12:24 p.m., the registered nurse manager (NM) stated if a resident experienced chest pain and Nitroglycerin was administered, staff were expected to obtain a full set of vital signs, including heart rate and blood pressure, ensure the resident was seated or lying down, apply oxygen as indicated, and assess the resident's signs and symptoms. The provider should be notified when Nitroglycerin was administered so the provider could determine whether additional doses or further interventions were needed. NM further stated NA's and nurses were expected to obtain daily weights promptly in the morning and document them in the medical record. Nurses were responsible for notifying the provider when weight changes met provider-established parameters. During interview on 2/12/26 at 1:39 p.m., the Director of Nursing (DON) stated she expected staff to obtain daily weights and notify the provider in accordance with provider-established parameter orders. Staff were expected to inform the provider if the resident was retaining fluids or if cardiac function appeared compromised. Regarding Nitroglycerin administration, the DON stated staff were expected to follow provider orders, obtain blood pressure and other vital signs prior to administration, and notify the provider when Nitroglycerin was administered. The DON confirmed the physician order required provider notification. The DON further stated, after the provider was notified of the resident's weight gain by the surveyor earlier that morning, the provider prescribed additional Lasix (diuretic) for five administrations and restarted Protonix on 2/12/26. During follow-up interview on 2/12/26 at 2:33 p.m., the DON stated staff relied on the provider order as written in the electronic medical record, which directed staff to contact the provider after three doses of Nitroglycerin had been administered. She further stated that although nursing staff were expected to notify the provider of chest pain or Nitroglycerin administration, this expectation was not consistently followed in practice, as staff deferred to the wording of the electronic order rather than notifying the provider with each administration. The facility Change in Condition policy, dated 4/6/25, indicated nursing judgment was to be used when determining the urgency of contacting the provider.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Office of the Ombudsman for Long-Term Care was notified of a resident's transfer to the emergency room (ER) on two separate occasions for 1 of 3 residents (R4) for transfer from facility.Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 had moderately impaired cognition and required assistance with activities of daily living (ADLs). R4's diagnoses included non-traumatic brain dysfunction (impairment of brain function affecting cognition or behavior not caused by physical injury), hypertension (chronically elevated blood pressure), urinary tract infections (infection of the urinary system), hyponatremia (abnormally low serum sodium levels), non-Alzheimer's dementia (progressive cognitive decline not attributed to Alzheimer's disease), and malnutrition (insufficient nutritional intake resulting in impaired health status). Review of R4's electronic medical record (EMR) on 02/11/26, indicated R4 was transferred from the facility to the emergency room on two separate occasions, 4/17/25 and 6/21/25. R4's transfer documentation, progress notes, and facility's Ombudsman notification logs failed to include documentation the Office of the Ombudsman for Long-Term Care was notified of either transfer. During interview on 02/11/26 at 3:37 p.m., the Health Information Manager (HIM) stated she reported unplanned hospital transfers to the Office of the Ombudsman for Long-Term Care and planned transfers were communicated in advance and coordinated with the Ombudsman. The HIM stated unplanned transfers were faxed to the Ombudsman on a monthly basis. The HIM reviewed facility records for hospital transfers dated 04/17/25 and 06/21/25 and verified both transfers were missing from her system. The HIM confirmed the transfers were not included in the monthly reports faxed to the Ombudsman and acknowledged the notifications were missed. The facility's Discharge and Transfer policy, dated 01/15/26, indicated when a resident was temporarily transferred on an emergency basis to an acute care center, a notice of transfer was required to be provided to the resident and resident representative as soon as practicable before the transfer. The policy further indicated copies of notices for emergency transfers must also be sent to the Office of the Ombudsman for Long-Term Care and may be provided when practicable, including as part of a monthly listing.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was completed and closed in accordance with federal requirements for 1 of 1 resident (R26) for accuracy of assessments. Findings include: R26's Medicare 5-day Minimum Data Set (MDS) assessment was initiated on [DATE], but was not completed or closed following the resident's transfer to the hospital. Record review indicated R26 was transferred from the facility to the hospital on [DATE]. R26 expired and did not return to the facility. Review of the MDS tracking system on [DATE], indicated the assessment remained open and exceeded 120 days without completion or closure. The MDS tracking system failed to include documented evidence the facility completed a required discharge assessment or took action to close the MDS following the resident's hospital transfer and death. During interview on [DATE] at 12:24 p.m., the Registered Nurse Manager (NM) stated the MDS assessment should have been closed or the Assessment Reference Date (ARD) changed following the R26's emergent hospitalization. R26 was transferred emergently to the hospital and the MDS should have been closed and left incomplete. The NM further stated a Medicare 5-day assessment should not have been completed. The NM reported being on vacation at that time, which NM stated may have contributed to the MDS not being closed appropriately. Review of the facility's MDS 3.0 RAI Policy, dated [DATE], indicated when a resident is hospitalized or discharged after a Medicare assessment has been opened but not completed, the facility must determine whether the MDS assessment is required for Medicare payment and take appropriate action to complete or close the assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Howard Lake	413 13th Avenue Howard Lake, MN 55349

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure comprehensive care plans were developed and updated to address identified needs for 2 of 2 residents (R1 and R4) reviewed for development of care plans.Findings include:R1:R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had severe cognitive impairment and required assistance with activities of daily living (ADLs) including transfers. R1's diagnoses included pneumonia, arthritis, non-Alzheimer's dementia, malnutrition, adult failure to thrive, and disorientation. The MDS also identified R1 required occasional assistance with locomotion and utilized a wheelchair for mobility.R1's comprehensive care plan, print date of 2/12/26, failed to address R1's locomotion status, including wheelchair use or the need for foot pedals for safe mobility. r1's care plan failed to include guidance outlining how staff were to assist R1 with transfers or wheelchair mobility.R4:R4's quarterly MDS dated [DATE], identified R4 had moderately impaired cognition and required assistance with ADLs. R4's diagnoses included non-traumatic brain dysfunction, urinary tract infections (UTIs), non-Alzheimer's dementia, and malnutrition. The MDS identified a history of urinary tract infections, and indicated an ongoing clinical condition which required monitoring and preventative interventions.R4's comprehensive care plan, print date of 2/12/26, failed to include problem, goal, or interventions addressing R4's history of UTIs.During interview on 2/12/26 at 12:04 p.m., nursing assistant (NA)-A stated a resident's care plan should identify the level of assistance needed for transfers and wheelchair mobility, including whether foot pedals were required. R1 did not like foot pedals and typically self-propelled throughout the facility. When staff assisted R1 by pushing R1 in the wheelchair, R1's feet would sometimes slide or bounce off the floor while being pushed down the hallway. NA-A was not aware of R4's history of UTIs.During interview on 2/12/26, NA-B stated the use of foot pedals should be identified on the care plan and if staff were pushing a resident in a wheelchair, foot pedals should be in place. R1 should have foot pedals because R1's feet sometimes slid on the floor when staff pushed the wheelchair. NA-B stated R4 had a history of UTIs and required staff reminders to drink fluids. NA-B stated interventions related to UTIs should be included on the care plan for staff to follow.During interview on 2/12/26 at 12:24 p.m., the registered nurse manager (RN)-B stated the use of foot pedals was determined by the resident's care plan and acknowledged some residents did not like foot pedals. Foot pedals could be kept in the resident's room for staff use when assisting with mobility. RN-B reviewed R1's care plan and confirmed wheelchair use and foot pedal use were not addressed. Floor nurses were able to update care plans. RN-B served as the final reviewer to ensure care plans were entered correctly and accurately. RN-B also stated R4 had a history of UTIs and, upon review of the care plan, stated R4 did not have an active UTI at the time and the issue was considered resolved. RN-B acknowledged R4's history of UTIs should be addressed on the care plan so staff were aware and could monitor for recurrence. RN-B expected the care plan included R4's history of UTIs.During interview on 2/12/26 at 1:39 p.m., the director of nursing (DON) stated wheelchair mobility depended on the individual resident; however, staff were advised not to push a resident in a wheelchair while the resident's feet were on the floor. The DON stated foot pedals should be in place when staff were pushing a resident in a wheelchair for resident comfort and safety. DON expected wheelchair mobility was addressed in the resident's care plan. The DON further stated nurses, care managers, and the DON were able to revise and add information to residents' care plans as needed. The DON also stated the facility addressed only active UTIs on care plans and did not address residents' history of UTIs, adding a resident's history of UTIs should be included on the care plan for prevention purposes.The facility's Care Plan policy, dated 12/1/25, indicated residents would receive the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. The policy further indicated each resident would have an individualized, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	person-centered, comprehensive care plan that included measurable goals and timetables to address identified medical, nursing, physical, functional, and psychosocial needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure residents received care and services in accordance with professional standards of practice to prevent avoidable harm for 1 of 1 resident (R1) observed during wheelchair transport.Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment and required assistance with activities of daily living (ADLs). R1's diagnoses included pneumonia (a lung infection), arthritis (joint inflammation causing pain and limited mobility), non-Alzheimer's dementia (a condition affecting cognition and functional abilities), malnutrition (inadequate nutritional status), localized edema (fluid-related swelling), adult failure to thrive (characterized by weight loss and functional decline), and disorientation (impaired awareness of person, place, or time). The MDS also indicated R1 required occasional assistance with locomotion and utilized a wheelchair for mobility. During observation on 2/9/26 at 7:52 a.m., R1 was being assisted to the dining room in a wheelchair. Nursing assistant (NA)-A pushed R1's wheelchair in the hallway. R1's wheelchair did not have foot pedals in place. R1's feet were observed bouncing off the floor on three occasions. During observation on 2/10/26 at 4:02 p.m., activity aide (AA)-A pushed R1, in the wheelchair, down the hallway. Foot pedals were not in place on R1's wheelchair. R1's feet were observed sliding on the floor. During observation on 2/10/26 at 4:40 p.m., AA-A was pushing R1, in the wheelchair, down the hallway toward the dining room without foot pedals in place. R1's feet were sliding on the floor. NA-C approached, stopped AA-A, and stated R1 should not be pushed unless foot pedals were in place. NA-C asked R1 whether he preferred to continue propelling himself to the dining room or if staff should obtain the foot pedals. R1 stated he would continue to self-propel to the dining room independently. This observation demonstrated differing staff practices regarding the use of foot pedals during wheelchair mobility. During review of R1's electronic medical record (EMR) on 2/11/26, R1's comprehensive care plan, print date of 2/12/26, revealed the care plan did not address the resident's locomotion status, including wheelchair use and whether foot pedals were required for safe mobility. There was no documented guidance outlining how staff were to assist the resident when R1 was in a wheelchair. During interview on 2/12/26 at 12:04 p.m., Nursing Assistant (NA)-A stated the resident's care plan should identify the level of assistance needed for transfers and wheelchair mobility, including whether foot pedals were required. NA-A reported the resident did not like using foot pedals and typically self-propelled himself throughout the facility. NA-A further stated that when staff assisted the resident by pushing his wheelchair, the resident's feet would sometimes slide or bounce off the floor. During interview on 2/12/26, Nursing Assistant (NA)-B stated that if staff were pushing a resident in a wheelchair, foot pedals should be in place. NA-B further stated the resident should have foot pedals because his feet would sometimes slide on the floor when staff pushed the wheelchair. During interview on 2/12/26 at 12:24 p.m., Registered Nurse Manager (RN)-B stated the use of foot pedals was determined by the resident's care plan and acknowledged some residents did not like foot pedals in place. RN-B stated foot pedals could be kept in the resident's room for staff use when assisting the resident. RN-B reviewed R1's care plan and confirmed wheelchair use and foot pedal use were not addressed. RN-B further stated any floor nurse could update care plans and that RN-B served as the final reviewer to ensure care plans were entered correctly and accurately. During interview on 2/12/26 at 1:39 p.m., the Director of Nursing (DON) stated wheelchair mobility depended on the individual resident; however, staff were advised not to push a resident in a wheelchair while the resident's feet were on the floor. The DON stated foot pedals should be in place when staff pushed a resident in a wheelchair and that this expectation should be addressed in the resident's care plan. The DON further stated nurses, care managers, and the DON were able to revise and add information to residents' care plans as needed. Facility policy related to wheelchair use was requested but was not received. The facility failed to ensure staff followed professional standards of practice for safe wheelchair transport, resulting in the potential for avoidable harm to the resident.