

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Specialty Care Community		STREET ADDRESS, CITY, STATE, ZIP CODE 3815 West Broadway Avenue Robbinsdale, MN 55422	
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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (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

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure foods which were a known allergen were not served or provided for 1 of 1 resident (R1) reviewed who complained about repeatedly being served such foods. This could cause an allergic reaction for R1 if she had consumed them. Findings include: R1's admission Minimum Data Set (MDS), dated [DATE], identified R1 had intact cognition and demonstrated no delusional thinking. On 7/30/25 at 8:52 a.m., R1 was interviewed in her room. R1 explained she had admitted to the care center a few weeks prior after being hospitalized for a motor vehicle accident (MVA), and she expressed several concerns about her care since admission. R1 stated she was repeatedly being served meals which had food items she was allergic to, such as seafood, which she said was frustrating. R1 stated she often then couldn't eat the meals so she was worried about losing weight. R1 held up a small, yellow-colored notepad and stated she had just that morning wrote out a list of items she wanted for the breakfast meal that day and gave it to the nursing assistant (NA) to help solve this problem. R1 added, I am going to be curious to see what my breakfast is. During the interview, at 9:00 a.m., NA-A knocked and entered the room with R1's meal tray in hand. The tray was placed on the bedside table next to R1, and R1 picked up the dome cover from the plate which exposed scrambled eggs and cut-up strawberries. R1 stated aloud that she was allergic to strawberries. NA-A then picked up a white-colored menu slip from the meal tray and expressed, It's on here even. The menu slip had R1's name along with a line of text which read, Allergies: Shrimp, Strawberries. The meal tray also had a piece of yellow-colored notepad paper on it with R1's handwritten order listed including scrambled eggs, milk, toast and butter. The handwritten note did not list strawberries. NA-A then picked up the plate and removed it from the room. R1 again reiterated this scenario as having happened repeatedly since she admitted a few weeks prior. Following, at 9:02 a.m., NA-A returned with a new meal tray and verified no strawberries were present. NA-A stated aloud, We have corrected that mistake. R1 responded aloud, That's good because I don't have an Epi-pen here. NA-A then left the room after leaving the meal tray on R1's bedside table. R1's electronic medical record (EMR) was reviewed. It contained a banner along the top of the page(s) which displayed various information including R1's name, room location, and date of birth (DOB). The banner included a section labeled, Allergies, which had red-colored font for each listed allergy. This included, . Shrimp, Strawberry . When interviewed on 7/30/25 at 9:10 a.m., dietary aide (DA)-A verified they had plated R1's food on the meal tray(s) just observed. DA-A explained the white-colored menu cards outline each resident' diet information along with their allergies. DA-A stated R1 had been mistakenly served strawberries because DA-A was more focused on reading the yellow-colored notepad order to ensure all the items she had requested were included. DA-A verified they did not review the white-colored menu slip before covering the plate as completed adding, I know she's a strawberry allergy but I didn't look at that [white-colored menu slip] cause I was looking at her notes [yellow-colored note]. DA-A stated the error was, Just a mix up. DA-A stated they would normally check the menu slip before serving a plate of food and reiterated, I just made a mistake. DA-A stated it was important to ensure residents weren't served known allergens as they could have a reaction. On 7/30/25 at 10:12 a.m., NA-A was interviewed, and they stated R1 was heavily dependent on staff for cares and ate most meals in her room via a room tray. NA-A verified they didn't check the white-colored menu slip before serving the plated food to R1 in her room adding aloud, I didn't check it. NA-A stated they didn't check it as the food had been covered with a dome already when they picked up the tray adding, I think it was an error. NA-A stated they would normally check the plated items to ensure accuracy before serving it to a resident. When interviewed on 7/30/25 at 10:17 a.m., registered nurse (RN)-A stated they had worked with R1 prior and reviewed R1's medical record. RN-A verified R1 as having a listed strawberry allergy and expressed it should be listed on her menu slip for the staff serving the food to be aware of and follow. RN-A added, They should know. RN-A stated they were unsure what type of allergic reaction R1 had to strawberries but added it could cause her (R1) to become short of breath. RN-A stated the staff member serving the plated food should also check the menu slip to ensure accuracy before handing it to the resident for consumption adding, They should double check it. On 7/30/25 at 11:15 a.m., the registered dietician (RD)-A was interviewed. RD-A stated a resident's allergen information pulls to their system from the EMR, and meal cards (i.e., menu slips) were printed every morning for R1's unit. RD-A stated the DA should be reviewing that slip to ensure the right texture and nothing with a listed allergy was served to the resident. RD-A verified the white-colored</p>		