STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mountain Lake	745 Basinger Memorial Drive Mountain Lake, MN 56159

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 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. Based on interview and record review the facility failed to develop/implement the care plan to include vulnerabilities for 3 of 3 residents (R1, R2, R3) who's care plans were reviewed for comprehension.R1R1's Face Sheet dated 2/16/22, indicated R1 had dementia and mild cognitive impairment. R1's Minnesota Vulnerable Adult Assessment (MVAA) dated 2/19/26, indicated R1 was unable to report abuse/ neglect concerns, defend self from verbal/physical attacks, and manage financial affairs. R1's care plan dated 4/29/26, did not identify or include the following vulnerability findings for R1: unable to report abuse/ neglect concerns, defend self from verbal/physical attacks, and manage financial affairs.R2R2's Face Sheet dated 10/9/2023, indicated R2 had mild cognitive impairment.R2'S MVAA dated 2/27/26, indicated R2 was unable to defend self from verbal and physical attacks and was unable to manage financial affairs. R2's care plan dated 4/29/26, did not identify or include the following vulnerability findings for R2: unable to defend self from verbal/physical attacks and manage financial affairs. R3R3's Face Sheet dated 10/23/25, indicated R3 had dementia, disorientation, and Alzheimer's Disease.R3's MVAA dated 4/8/26, indicated R3 was unable to report abuse/ neglect concerns, defend self from verbal/physical attacks, and manage financial affairs.R3's care plan dated 4/29/26, did not identify or include the following vulnerability findings for R3: unable to report abuse/ neglect concerns, defend self from verbal/physical attacks, and manage financial affairs.During an interview on 4/23/26 at 12:30 p.m., nursing assistant (NA)-A stated she would look at the resident care plan or Kardex for needs a resident might have and how to meet those needs.During an interview on 4/23/26 at 1:23 p.m., NA-B stated on 4/11/26 around 10:00 p.m., she went into R1's room and found R2 in his wheelchair on the right side of R1's bed, with R1 lying in bed with R1's pants down and brief to the side. R2 was touching R1's vaginal area with his left hand. R1 had her eyes closed but R1's eyebrows were scrunched together. NA-B stated she was surprised by this observation. NA-B stated she left R1 and R2 in the room to get the nurse. NA-B did not stop the interaction. NA-B stated she would look in a resident care plan or Kardex for any resident needs or interventions.During an interview on 4/29/26 at 1:45 p.m., Social Services (SS)-A stated she would complete the MVAA and once complete she would address the findings in the care plan. SS-A stated there was nothing in the care plan about vulnerabilities specifically because it was assumed everyone was a vulnerable adult and the facility treated all residents as such.During an interview on 4/29/26 at 3:42 p.m., director of nursing (DON) stated SS-A would be responsible for completing the MVAA. All vulnerabilities should be care planned.The facility Comprehensive Care Plan policy revised 12/29/25, indicated the facility would develop a person-centered care plan that would meet the residents physical, mental, spiritual, and psychosocial well-being.

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to follow care planned fall interventions for 1 of 3 residents (R5) reviewed for falls. This resulted in actual harm when R5 fell and required a visit to the emergency department resulting in a fractured left femur and needed surgical intervention. The facility had implemented appropriate corrective action prior to the onsite investigation, so the deficiency is being cited at past non-compliance.ˆ Findings include:R5's quarterly Minimum Data Set (MDS) dated [DATE], indicated R5 had moderate cognitive impairment, needed substantial to maximal assistance with toileting, and needed partial to moderate assistance with toilet transfersR5's Face Sheet dated 6/23/23, indicated R5 had dementia.R5's care plan with intervention revision dated 7/16/25, indicated R5 had an actual fall with no injury related to poor vision and unsteady gait. Intervention included: staff to toilet resident during 4:00 a.m. rounding. R5's fall tool dated 8/31/25, indicated R5 was at high risk for falls.R5's Emergency Department (ED) note dated 1/28/26, indicated R5 had a fall resulting in a closed fracture of left hip.R5's [NAME] Accountability For Excellence (SAFE) Event- Incident Report dated 1/28/26, indicated at 6:15 a.m., R5 had a fall, was sent to the ED and X-ray verified a left hip fracture.R5's progress notes dated 1/28/26:6:15 a.m., R5 was found on the floor and stated she was trying to use the bathroom.6:30 a.m., indicated R5 was complaining of left hip, knee, and leg pain.7:51 a.m. R5 was sent into the ED.9:58 a.m., facility was notified R5 had a left hip fracture. R5's Orthopedic Surgery note dated 1/29/26, indicated R5 had a closed displaced left femoral neck fracture and needed a left hip hemiarthroplasty (femoral head joint replacement).During an interview on 4/22/26 at 3:15 p.m., R5 stated she had a fall in 1/2026 but could not recall the date. R5 hurt her left leg and had to go to the hospital. Before the fall R5 was trying to get up to go to the bathroom. R5 did not think staff offered to take her to the bathroom before her fall.On 4/23/26 at 12:30 p.m., nursing assistant (NA)-A stated on 1/28/26 between 2:00 a.m. and 4:00 a.m., NA-A checked on R5 but did offer toilet assistance to R5. NA-A stated she was not aware R5 needed to be toileted during 4:00 a.m. rounds because it was not on R5's Kardex. NA-A stated she did not look at the care plan prior to her shift. NA-A stated she should have looked at R5's care plan prior to caring for R5.On 4/29/26 at 2:40 p.m., nurse practitioner (NP)-A stated the fall R5 had could have been prevented if staff would have followed the care plan and toileted R5 during 4:00 a.m. rounds.On 4/29/26 at 3:42 p.m., director of nursing (DON) stated staff are expected to follow resident care plans. DON put the intervention to toilet R5 during 4:00 a.m. rounds in R5's care plan. DON thought the intervention was on R5's Kardex but it was not. The facility now double checks the Kardex to ensure all interventions are in place.On 4/29/26 at 4:07 p.m., administrator stated staff are expected to follow the care plan. The administrator was made aware R5's toileting intervention was not on the Kardex after discussion with the DON.The facility Fall Prevention and Management policy revised 3/31/26, indicated the facility would communicate fall interventions to prevent a fall per the 24-hour report, care plan and Kardex.The facility implemented corrective action to prevent recurrence by 2/3/26 when the facility completed the following: provided education to all nursing staff on updating interventions, following care plans, and fall risks, reviewed all high fall risk residents and updated care plans, and completed high fall risk audits to ensure fall interventions were care planned and pulling to the resident Kardex. Verification of corrective action was confirmed by observation, interview, and document review on 4/22/26 and 4/29/26.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure medications were administered to the correct resident for 1 of 3 residents (R3) reviewed for medication errors. This failure resulted in actual harm for R3 when she developed bradycardia (abnormally slow heart rate) which required ongoing monitoring and intravenous therapy in the emergency department (ED).ˆThe facility had implemented appropriate corrective action prior to the onsite investigation, so the deficiency is being cited at past non-compliance.ˆ R3's Face Sheet dated 10/23/25, indicated R3 had dementia and Alzheimer's Disease. R3's [NAME] Accountability For Excellence (SAFE) Event Incident Report dated 3/25/26, indicated R3 was found with another resident's crushed medications in a drink. R3 became sleepy and was sent to ED.ˆ R3's Weights and Vitals Summary dated 3/25/26, indicated R3's pulse was 47 beats per minute (BPM) at 6:11 p.m. At 6:44 p.m., R1's pulse was 40 bpm. On 3/25/26 R3's progress note indicated: 5:23 p.m., R3 was sitting at the dining table across from another resident who had crushed medications in a glass of liquid. R3 was seen with the glass of liquid in her hand. After ten minutes, R3 was sleeping at the dining room table. 5:45 p.m., poison control was called due to R3 getting an unknown amount of high dose blood pressure medication, facility was directed to send R3 to the ED if her pulse dropped below 45 consistently. 6:30 p.m., pulse continued to decrease 42-44 BPM and at times dropped to upper 30's, R3 was sent to ED for hydration.ˆ R1's Emergency Department Note dated 3/25/26, indicated R3 was at the table in the dining room and took another residents medications: valproic acid (seizure medication) 125 milligrams (mg)/ 5 milliliters (mL); carbidopa/ levodopa (Parkinson's disease medication) ˆ25/100mg; glycopyrrolate (peptic ulcer medication) 1mg; metoprolol (high blood pressure medication) 75mg; and Remeron (antidepressant) 7.5mg. ˆR3 was lethargic and diagnosed with medication overdose. R3 was given intravenous normal saline 500 mL bolus with glucagon (diabetes medication) 5mg. R3's pulse had dropped to 37bpm consistent with metoprolol ingestion. During an interview on 4/22/26 at 4:13 p.m., registered nurse (RN)-A stated he got R4's medications ready in a glass of liquid and set the cup in front of R4 then RN-A walked away. R3 grabbed R4's glass of crushed medications and drank out of the glass. R3's pulse started to decrease so R3 was sent to the ED. RN-A stated he should not have left R4 alone with his medications. RN-A stated he should have stayed with R4 until all of his medications were taken. On 4/29/26 at 2:40 p.m., nurse practitioner (NP)- A stated if the facility would have followed the medication administration policy and procedure R3 would not have ingested R4's medications and would not have been sent to the ED. R3's pulse was normally around 60 bpm so a pulse of 37 bpm was concerning. On 4/29/26 at 3:01 p.m., consultant pharmacist (CP)-A stated R3's pulse being above 50 bpm would not have been concerning but a pulse of 37 bpm was concerning. Glucagon was given to R3 to reverse the effects of the metoprolol overdose.ˆ On 4/29/26 at 3:42 p.m., director of nursing (DON) stated staff would be expected to stay with the resident when taking medications unless they were assessed and had orders to take medications alone. RN-A should have never left R4's medications on the table, RN-A should have stayed with R4 until his medications were taken. On 4/29/26 at 4:07 p.m., administrator stated staff were expected to stay with residents when giving medications until they were taken, unless the resident was assessed and safe to take medications alone. R4 was not safe to take medications alone. The facility Medication Administration policy revised 3/30/26, indicated staff would not leave medications with a resident unless a specific physician order was in place to do so and the resident was evaluated for self- administration of medications. The facility implemented corrective action to prevent recurrence by 3/31/26, when the facility completed the following: provided education to all staff members responsible for medication administration, which included administration of medications and self-administration of medication, observed all residents with self- administration of medication orders and updated care plans, and completed medication administration audits. Verification of corrective action was confirmed by observation, interview, and document review on 4/22/26 through 4/29/26.