

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Mountain Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and document review, the facility failed to reconcile liquid controlled narcotic medications in 1 of 2 medication cart to prevent potential diversion for 5 sampled residents (R7, R8, R26, R36, and R53). Findings include: Observation and interview on 8/11/26 at 2:13 p.m., with registered nurse (RN)-B and licensed practical nurse (LPN)-A as they completed the change of shift narcotic count. RN-B counted the narcotic pills located in the medication cart locked box while LPN-A confirmed the count. RN-B finished with the narcotic pills and proceeded to shut and lock the lock box located in the medication cart and then lock the medication cart. RN-B did not pick up or confirm the amount of 7 bottles of liquid narcotic medications also located in the locked box. RN-B stated, we don't count morphine as it is hard to tell as a liquid, RN-B did confirm the facility documented in the narcotic book when they administered the liquid narcotic medications. Located in the locked box within the medication cart that was not reconciled was: R7's Morphine liquid 20 milligram (mg)/per milliliter (ml), 21.5 ml R8's Morphine liquid unknown strength, 24 ml R23's Morphine liquid 20 mg/ml, 28.25 ml R26's Codeine liquid solution, 68 ml R36's Morphine liquid 100mg/5ml, 23.5 ml R36's Morphine liquid 100mg/5ml (2nd bottle), 25.75 ml R53's Lorazepam liquid solution, 30 ml LPN-A confirmed that the facility had not been verifying the liquid narcotic medication. Interview on 8/11/26 at 2:20 p.m., with RN-C reported all the narcotics should be reconciled including the liquid narcotics. Everything that was in that locked box should be counted to confirm the correct amount remained. Interview on 8/11/26 at 2:22 p.m., with RN-A confirmed all narcotics should be counted shift to shift to verify the amount. She would expect that each nurse completed narcotic counting would be checking all controlled medications. Interview on 8/11/26 at 2:57 p.m., with director of nursing (DON) identified nurses should be counting all narcotics shift to shift between 2 staff. Liquid narcotics should be counted even though they can be hard to count. She was not aware that the nurses were not counting the liquid narcotics and stated, I wonder how long they have not been doing that. She confirmed that staff are to count each narcotic medication liquid or pill to confirm amount. Interview on 8/12/26 at 11:21 a.m., with regional clinical service director identified she would expect that the facility was reconciling all controlled medications shift to shift to monitor for diversion. Staff should be taking each medication out of the locked box and verifying the count including the liquid medication. Interview on 8/12/26 at 1:48 p.m., with consulting pharmacist identified she would have expected that the facility staff would be reconciling all controlled medication. She revealed she did quarterly medication pass audits; however, was not usually there at time of narcotic count between shifts but when she was there, she would review the narcotic book. She would expect a system to be in place to count and monitor all controlled medications for potential diversion. Review of the 6/30/26, Medications: Controlled policy identified reconciliation was a system to monitor controlled medication. All controlled medication would be verified when delivered and documented in the bound narcotic (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record book. Each time the keys that secured the controlled medication locked box the oncoming and off-going nurse/medication aide would reconcile all the controlled medications to ensure the count matched the remaining amount listed.		

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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 interview and document review the facility failed to notify the ombudsman of 1 of 2 (R49) sampled resident discharges. Findings include: R49's 6/17/26, accepted discharge Minimum Data Set (MDS) assessment identified R49 was discharged to his home/community with return not anticipated. R49's 6/25/26, discharge summary identified he was independent with activities of daily living (ADLS) following completion of skilled physical and occupational therapies. His cognition was intact, and the decision was made to transfer to Assisted Living following discharge. Interview on 8/11/26 at 10:29 a. m. with registered nurse (RN)-D reported R49 had originally transferred from the [NAME] facility where he was originally admitted following hospitalization. He was admitted for skilled therapies, and following completion he and his family made the decision to discharge to the local Assisted Living facility. Interview on 8/12/26 at 8:09 a.m. with the director of nursing (DON) and licensed social worker (LSW) identified they were not aware the ombudsman was supposed to be informed when residents voluntarily discharged to the community, and as a result had not done so. Email response on 8/12/26 at 10:36 a.m. from the Ombudsman reported she had reviewed documentation she had received from the facility, and she was only being informed of residents that went to the hospital. She identified she should have been notified of all resident discharges and transfers regardless of the destination. Interview on 8/12/26 at 1:02 p.m. with the administrator reported she was not aware appropriate notifications of transfers or discharges were not being provided to the Ombudsman. She identified her expectations for the notification requirements to be followed. Review of January 15, 2026, Discharge and Transfer policy identified when a resident was transferred or discharged , the location must send a notification to the Office of the State Long-Term Care Ombudsman.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure employee illnesses were tracked to identify when employee would be able to return to work after an illness, depending upon their symptoms for 2 of 3 sampled staff (nursing assistant (NA)-B with gastrointestinal illness. Findings include: Review of the 2024-2025 Norovirus Information for Long-term Care Facilities, located at, https://www.health.state.mn.us/diseases/foodborne/outbreak/facility/ltcfnorotoolkit.pdf, identified Norovirus is transmitted through a fecal (stool)-oral route with symptoms of diarrhea, vomiting, nausea, abdominal pain, low grade fever, headache, and or body aches. Individuals generally become ill 12-48 hours after exposure (swallowing Norovirus). Infected individuals shed the virus in their stool and contaminate food, surfaces, and objects and can be shed in the stool for several weeks after recovery. Products used to clean Norovirus must say they are effective against Norovirus. Hand sanitizer does not work to kill the virus. Individuals should wash their hands for 20 seconds with soap and water. Individual cases of Norovirus are not reportable to the State, however, possible outbreaks or multiple cases with Norovirus-like symptoms must be reported. Documentation of possible outbreaks was to include: Use the RESIDENT ILLNESS LOG and STAFF ILLNESS LOG to document illnesses among staff and residents/patients: Contact managers of each unit, etc. as necessary to gather illness information. Send both ILLNESS LOGS back to MDH within 2 business days of reporting the suspected outbreak. Epidemiology staff will use this to assess A) which pathogen is causing the outbreak, B) the likely route of transmission, and C) whether additional prevention measures are needed. Gather additional information List activities, events, etc., held during the week prior to the first illness (especially if food was served). Determine when and where there were any vomiting incidents or diarrheal accidents in the facility. If requested by MDH, provide a dietary menu (breakfast, lunch, and dinner). If requested by MDH, provide names and phone numbers for staff and/or residents (in rare cases, MDH may want to conduct interviews). Collect a stool sample from three (3) residents and/or staff and send to MDH Laboratory for analysis (MDH will provide specimen collection kits; the testing is free of charge). If stools from residents or staff were sent to a clinical laboratory, notify MDH of any results. Send both completed ILLNESS LOGS back to MDH between 1 and 2 weeks after the last illness. IMPLEMENT OUTBREAK CONTROL MEASURES: Monitor for resident illness (record on RESIDENT ILLNESS LOG) and when possible, isolate residents while they are ill and for 72 hours after symptoms have stopped. Consider halting new admissions until the outbreak has ended. Exclude actively ill residents from games/activities where touching common items occurs (e.g., checkers, cards). Monitor for staff illness (record on STAFF ILLNESS LOG) and restrict ill staff/volunteers from patient care and food handling duties until 72 hours after their vomiting/diarrhea has ended. Review of the current, undated Centers for Disease Control (CDC) Norovirus guidelines, located at https://www.cdc.gov/norovirus/index.html, identified Norovirus is a very contagious virus that causes vomiting and diarrhea. It is sometimes called the stomach flu or the stomach bug. However, norovirus illness is not related to the flu. The flu is caused by the influenza virus. Norovirus causes acute gastroenteritis, an inflammation of the stomach or intestines. Most people with norovirus illness get better within 1 to 3 days; but they can still spread the virus for a few days after. Most common symptoms: Diarrhea, vomiting, nausea, stomach pain. Other symptoms: Fever, headache, and body aches. Food workers should stay home when sick and for at least 48 hours after symptoms stop. This also applies to sick workers in schools, daycares, healthcare facilities, and other places where they may expose people to norovirus. Review of the March 2026 through June 2026, Employee (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Absence [NAME] Report, Employee Call out logs, and comparative timesheets identified: LPN-A was noted to have called in to work with symptoms of diarrhea (loose watery stool) on 3/21/26. LPN-A reported to be absence/[NAME] on 3/22/26. Employee timesheets identified LPN-A returned to work on 3/24/26. There was no indication LPN-A had been screened prior to coming back to work to ensure they had been removed from patient contact for 48-72 hours after symptoms resolved. NA-B was noted to have called in to work with symptoms of nausea, vomiting and diarrhea on 6/20/26. NA-B was reported to be absence/[NAME] on 6/20/26 with symptoms of a sore throat, nausea, vomiting, and diarrhea. Employee timesheets identified NA-B returned to work on 6/21/26. There was no indication NA-B had also been screened prior to coming back to work to ensure they had been removed from patient contact for 48-72 hours after symptoms resolved. Overall, there was no mention on the Absence/[NAME] Reports when or if LPN-A or NA-A's symptoms resolved prior to returning to work. The section at the bottom of the report sheet to identify if an employee was clear to work was left blank. Interview on 8/12/2026 at 11:52 a.m., with registered nurse (RN)-C, who is the Infection Preventionist (IP) revealed both director of nursing (DON) and IP tracked employee call outs and illnesses electronically. She acknowledged she provided oversight and did not implement appropriate monitoring of employee illnesses when they occur. Interview on 8/12/2026 at 12:50 p.m., with DON stated the employee Absence/[NAME] Report sheet was used to track employee illnesses at the facility. She acknowledged the sheet should have been filled out appropriately to determine whether an employee illness was resolved and/or if it was clear for the staff to return to work. Review of 9/23/25 Employee Health Conditions Reporting and Managing, Infection Control-Rehab/Skilled, Senior Living policy identified the administrator, or designee was responsible to ensure supervisors and staff were trained and understand the importance of reporting and managing employee illness and symptoms. Employees were to consult their supervisor to evaluate the condition and consult the IP, if available. Employees returning after an illness were to consult their supervisor and the supervisor may involve clinical members, such as the IP, DON, or a licensed nurse. Review of 3/25/26 Identification/Surveillance, Management, and Reporting of Suspected/Confirmed Infections, AL, R/S, LTC, Home Health, Hospice policy identified the IP or appointed designee, was to review additional information to identify indicators of infection, collect data to confirm/suspected infections, such as employee illness records to determine disease and/or outbreak reporting requirements.		