STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Mary Jane Brown	110 South Walnut Avenue Luverne, MN 56156

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to monitor, clean 1 of 1 refrigerator in the dining room designated for food brought in for residents by family members. This had the potential to affect all 45 residents in the facility. Findings include: Observations on 3/30/26 at 11:53 a.m. with Cook-A of the refrigerator, located in the dining room, used for resident food brought into the facility from outside sources identified a log was posted on the front of the refrigerator titled Resident Fridge Food Items. On the log there were entries for Resident, Food item, Arrival Date, Open date, and Expiration Date. The log had dates of 3/17, 3/18, 4/19, 4/21, but no indication of the year was identified. The next dates were 12/28/25, 12/29/25, 12/30/25, and 3/5/26. A second sign, identifying instructions titled for Resident Food Only listed:All food must be labeled with name and date-Please use labels next to fridge.Food will be thrown away if it is expired.All food in open containers over 7 days will be thrown out.All food deemed inedible (ie: moldy, contaminated or curdled) will be thrown outLeftovers from meals served by the facility will not be kept.Only food for residents is to be stored here. Continued observation 3/30/26 at 11:53 a.m. with Cook-A identified inside of the refrigerator there were multiple bags, bottles, takeout food containers, and containers of condiments. Dried spills were noted on the lids and outside of the condiment containers. There were dried spills of a red colored liquid and food like particles noted on the shelves. A red dried liquid substance was puddled on the second shelf and it extended onto the lower shelf and into the freezer compartment, located on the lower portion of the refrigerator. Items in the refrigerator included:One bottle of Cocktail sauce, (usually bright red in color) had a dark, dried appearance and the cover was held open with a buildup of dried sauce under the lid and on the outside of the bottle. The bottle had no date of opening or identified a resident name. One 32-ounce (OZ) carton of heavy cream, with an manufacture's expiration date of 3/20/26. The carton did not contain a date when it was opened or a resident name. One tube of [NAME] (ready to eat sausage), opened with the paper partially wrapped over the open end of the tube. There was no date of when it had been opened, nor a resident name on the sausage. One small bowel (identified as dished from a large container) contained apple sauce and had been dated from the kitchen with a date of 1/2/26. The container had no resident name, and Cook-A indicated the date was when it had been prepared in the kitchen and likely taken from a meal tray. One-32 oz carton of egg nogg which had been opened and did not have a resident name or date when opened. 1 Takeout foam container with resident name no longer at the facility and a date of 2/5/26.1Takeout foam container dated 3/12/26, and no resident name1 folded down paper bag containing a package of Deli meat and a takeout foam container. Neither of the items had a resident name or date.1 opened single serving snack pak, that had no name or date.1 opened Taco dip platter that contained a white mold-like, furry substance on the surface of the dip. There was resident name or date.One 32 OZ bottle of coffee creamer opened and had a manufacture's date of 1/4/26. There was no resident name on the container. One 16 oz carton of sour cream which had been opened but had resident name or date to be discarded. 1 Bottle of Iced coffee with no resident name or date to be discarded.1 Bag containing 4 bagels dated 2/13/26, with no resident name identified. 1 Paper bag (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	which contained a 1 lb bag of baby carrots that appeared slimy. There was no name or date.1 avocado which was black, soft, mushy and had no resident name. The Freezer located below the refrigerator was also observed to have spilled food items. 3 cartons of ice cream- 1 sealed, 1 open with the ice cream dried and had a cracked appearance, and a second which had been opened and a portion removed. Neither a resident name or date. 1 small round plastic container with a partially frozen red liquid inside and appeared to have spilled and frozen on in the freezer compartment. There was no resident name, or date on the container. Interview on 3/30/26 at 11:50 a.m. with cook-A identified dietary staff were responsible for the monitoring and cleaning of the Resident Food Refrigerator. He identified there was not a schedule or assignment list for cleaning and checking of the refrigerator and freezer. He also reported he had no idea when it had last been checked, and he would make certain it was cleaned right away. Interview on 4/01/26 at 9:51 a.m. with the administrator reported they did not currently have a certified dietary manager, or person that was certified as Serve Safe. She identified Cook-B had completed SERV Safe training and would take the test, which was completed on 3/30/26. The administrator had a documented plan for management of the dietary department by utilizing a certified dietary manager (CDM) from a sister facility in addition to the Registered Dietitian. She identified that the previous CDM had left the faciity on 3/27/26 and both the CDM and registered dietitian had assessed the status of the dietary department on 3/28/26. She confirmed the resident refrigerator in addition to other items in the kitchen had included a newly developed cleaning schedule and would be monitored to ensure compliance. She stated she was not aware the dietary department had not been maintained to her expectations and would be monitored to ensure compliance. Review of the plan for management of the dietary department included oversight by the sister facility certified dietary manager and registered dietitian. Education was initiated for dietary staff to ensure knowledge of policies and procedures, and a cleaning schedule was being implemented. A policy for cleaning of the resident designated refrigerator was requested but not provided by survey exit.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and document review the facility failed to submit complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data, during 1 of 1 quarter reviewed (Quarter 4) 2025 (July 1 through September 30) to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS.Findings include: Review of the Payroll Based Journal Report (PBJ) [NAME] Report 1705 D identified the facility had excessively low staffing during Quarter 4, 2025 (July 1 through September 30). Review of the 1702D report for quarter 4 of 2025 (July 1 through September 30) and staffing schedules identified during an average week, Monday through Friday, during the day shift, there were several days that multiple registered nurses had been working. These hours had been submitted to PBJ as direct care RN'S rather than RN's with administrative duties. For example, on:8/26/25, 6 registered nurses were coded as RN's (direct care staff with no administrative duties) on the report. Staffing schedules identified 4 of 6 RN's were scheduled for administrative duties (RN-E, RN-C, RN-D, and the DON) and should not have been coded as direct care staff.8/27/25, 6 registered nurses were coded as RN's (direct care staff with no administrative duties) on the report. Staffing schedules identified 4 of 6 RN's were scheduled for administrative duties (RN-E, RN-C, RN-D, and the DON) and should not have been coded as direct care staff.9/30/25, 5 registered nurses were coded as RN's providing direct care on the report. Staffing schedules identified 3 of those RN's were scheduled for administrative duties (RN-E, RN-C, and RN-D) and should not have been coded as direct care staff. Interview on 4/1/26 at 9:57 a.m., with the director of nursing (DON) identified they had not separated weekday RN'S with administrative duties from RN'S who provide direct care to residents on the PBJ submission information. The DON reached out to an unidentified corporate manager who further revealed they were unaware RN'S with administrative duties should be coded by their job type and category and not as direct care RN's. The corporate manager and DON confirmed this was likely the reason for the staffing discrepancy between the weekday and weekend staffing hours. A policy was requested; however, none was provided by the end of the survey period.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure enteral feeding tube placement was confirmed prior to initiation of a feeding for 1 of 1 resident (R2). Findings include: R2's, undated, current Medical Diagnosis list identified diagnoses of hemiplegia (total loss of voluntary movement on one side) and hemiparesis (partial weakness, allowing some movement) following cerebral infarction (stroke) affecting his left side, dysphagia (difficulty swallowing), and severe cognitive impairment. R2's 1/28/26, quarterly Minimum Data Set (MDS) assessment identified he had severe cognitive impairment. R2 received 51% or more of his total calories through tube feeding, and 501 cc/day or more fluid intake by tube feeding. R2's current undated care plan, identified he had a nutritional problem or potential related to neuromuscular impairment and swallowing dysfunction (Dysphagia) following a stroke evidenced by hemiplegia and hemiparesis of his left side. Staff were to weigh R2 daily. And monitor/report to the nurse any signs or symptoms of complications of the tube feeding, such as (coughing, choking, nausea, or loose stools, etc.). R2 was to receive Osmolyte 1.5calorie at 80cc/hour for 4 hours via pump (through G-tube). R2's, 3/19/26, Clinical Physician Orders identified he was to receive enteral feeding two times a day, at 80cc/hr. via pump for 4 hours. Staff were to flush the tube with 20cc of water every one hour during the tube feeding. Medications were to be crushed and mixed with pudding or administered via the G-tube. Staff were to flush the tube with 30cc of water before and after medications administered via the G-tube and document the total amount of fluid administered. Observation on 3/30/26 at 7:31 p.m., with licensed practical nurse (LPN)-A while administering a tube feeding to R2 identified she obtained the required items to administer R2's tube feeding. She washed her hands, donned personal protective equipment (PPE), gathered the supplies and entered R2's room, where she explained she needed to set up his tube feeding. LPN-A took a graduated container into the bathroom and filled it with 700cc of tap water, which she placed into a new feeding bag and hung on the pump stand. She was not certain how much water was supposed to be placed in the second feeding pump bag, but she usually filled it with 600-700 cc. She then returned to the bathroom and refilled the graduated container with tap water, which she identified was for the 30cc G-tube flush. LPN-A filled a second new feeding bag, with 320 cc of Osmolyte 1.5 calorie nutritional feeding formula. She then primed the tubing and hung the tubing on the pump stand. She then told R2 she was going to hook up his feeding, moved his shirt to expose the G-tube, checked the clamp, filled the syringe with 30 cc of water from the container, opened the tube stopper, wiped with an alcohol pad, placed the syringe into the G-tube port. LPN-A then opened the clamp and pushed the water into the G-tube. She then removed the syringe with the plunger fully depressed, connected the feeding to the G-tube, checked the settings on the pump and confirmed it was set at 80cc/hour and turned on the pump. She then rechecked the G-tube to ensure the clamp was open. LPN-A failed to perform any checks to determine the G-tube was still in R2's stomach. Interview on 3/31/26, at 7:40 p.m. with LPN-A reported she had followed her usual procedure for flushing and administering the feeding through R2's G-tube. She identified she had not checked placement before administering the flush or starting the feeding, and she had not been trained to do so. Interview on 3/31/26 at 5:19 p.m. with the director of nursing (DON) identified nursing staff received training on tube feedings at orientation, which was documented on the orientation checkoff list. LPN-A's training was last completed in October 2025. Her expectation was for all nursing staff to follow the facility policy for administering G-tube feedings or medication administration. Following the above observation the nurse on duty had reviewed the procedure with LPN-A. Review of the October 2025, [NAME] Policy Tube-Gastrostomy or Jejunostomy-Enteral Feeding, Care, Replacement or Removal identified only licensed nurses were to administer tube feedings, with conformation of the type of feeding, rate of infusion if a pump was utilized, or gravity if (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no pump was used, in addition to the volume of feeding to be administered. The procedure identified the steps to be followed for administration:1). Verify the order.2). Follow EBP.3). Staff were to perform Hand hygiene before handling formula or equipment and ensure the equipment and formula was placed on a clean surface and apply gloves prior to beginning the procedure.4). Confirm correct feeding by checking orders and identifying the resident to receive the feeding. Check the expiration date, and ensure the formula was at room temperature.5.) Elevate the head of the bed 30-45 degrees during the feeding and keep it elevated for 30-60 minutes after feeding, unless a physician's order instructs otherwise.6). Check tube placement and patency before beginning a feeding or administering fluids or medications. Methods for checking include: a. Observe for change in the external length of the tube, by checking change in location of a mark placed on the tube on the level where it exits the skin. b. Remove the cap or plug from the feeding tube and use the syringe to inject 30 milliliters of air through the tube to clear it, then aspirate for observation of gastric contents to ensure the tube remains in the stomach.