Electronically Delivered

February 10, 2026

Licensee
Good Samaritan Society-Woodland
200 Buffalo Hills Lane
Brainerd, MN 56401

RE: Project Number(s) SL30309016

Dear Licensee:

On February 5, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on November 20, 2025. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

CLN

Electronically Delivered

January 8, 2026

Licensee
Good Samaritan Society-Woodland
200 Buffalo Hills Lane
Brainerd, MN 56401

RE: Project Number(s) SL30309016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 20, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed

pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30309	A. BUILDING: _____ B. WING _____	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-WOODLAND	200 BUFFALO HILLS LANE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30909016-0 On November 17, 2025, through November 20, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 124 residents; 64 receiving services under the Assisted Living Facility license. An immediate correction order was identified on November 19, 2025, for tag identification 2310 at a scope and level of isolated, three (G). The licensee took action to mitigate the risks, however, the scope and level remain G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 17, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of two employee (unlicensed personnel/ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 510		

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0 510	Continued From page 4 On November 18, 2025, at 8:05 a.m., the surveyor observed ULP-C perform a blood glucose check for R3 in her apartment. With gloved hands, ULP-C poked R3's finger with a lancet, enter the blood glucose results into the electronic medical record on the computer, pull the insulin pen from the cupboard, and realized no alcohol wipes were in the apartment. At this time, ULP-C opened the apartment door, removed the gloves while walking down the hall, opened the medication/storage room door, talked on the phone while grabbing a box of alcohol wipes, spoke into the walkie talkie, returned to R3's apartment after opening the door, performed hand hygiene, and put on clean gloves. On November 19, 2025, at 1:00 p.m., ULP-C stated she was trained to do hand hygiene after performing a blood glucose check, but stated some residents did not have paper towels in their rooms and staff were told not to use resident's regular towels. ULP-C stated they were provided small bottles of hand sanitizer to utilize. On November 20, 2025, at 1:40 p.m., clinical nurse supervisor (CNS)-A stated staff were expected to perform hand hygiene before entering a resident room, after done with resident cares, after performing a blood glucose check and after removing gloves. CNS-A stated staff were trained on this. The licensee's Handy Hygiene policy dated November 13, 2025, noted staff were to perform hand hygiene when entering a room, before a clean task, after bodily fluid/glove removal, and upon exiting a room. The Centers for Disease Control's (CDC), "CDC's	0 510		

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0 510	Continued From page 5 Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated April 12, 2024, under section 5a.1 indicated: 1.) Require healthcare personnel to perform hand hygiene in accordance with CDC recommendations. 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency	0 650		

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0 650	Continued From page 6 evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of three employees (unlicensed personnel/ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 17, 2025, at 9:40 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they were aware of the required contents of the employee records. ULP-D was hired on June 25, 2025, to provide	0 650		

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0 650	Continued From page 7 direct care services to residents of the facility. ULP-D's record lacked documented evidence of the following orientation requirements: - handling of resident complaints, reporting of complaints, and where to report; - review of the types of Assisted Living services the employee would provide and the provider's scope of license; and - principles of person-centered planning and service delivery. On November 20, 2025, at 9:40 a.m., LALD-B stated she covered these topics in the orientation, but it was not documented in any employee records. The licensee's Required Training for All Employees, Minnesota - Assisted Living policy dated June 11, 2025, noted the facility would retain evidence in the employee's record of having completed the orientation and training required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 660	Continued From page 8 and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of three employees (unlicensed personnel/ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Facility TB Risk Assessment dated February 18, 2025, indicated the licensee was a low risk. ULP-D was hired on June 25, 2025, to provide direct care services to residents of the facility.	0 660		

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0 660	Continued From page 9 ULP-D's record included a TST dated June 26, 2025. However, it lacked a second step TST. On November 20, 2025, at 9:40 a.m., licensed assisted living director (LALD)-B stated ULP-D had received the TST through another employer and had completed the second TST. However, the second TST had not been provided by ULP-D. The licensee's Tuberculosis Control Plan and Screening for Employees, Senior Living, Rehab / Skilled Home Health, Hospice, Child Day - Enterprise policy dated June 1, 2025, noted "Employees that have received a documented negative TB skin test in the past 12 months will be required to have a single TB skin test only. This test represents the second step of 2-step testing." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, it noted TST documentation should include the date of the test, the number of millimeters (mm) of induration (if no induration, document "0" mm) and the interpretation (positive or negative). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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0 660	Continued From page 10 (21) days	0 660		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30309	A. BUILDING: _____ B. WING _____	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-WOODLAND	200 BUFFALO HILLS LANE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 11 provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document significant changes in the resident's status including reporting to the appropriate supervisor for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included gastro-esophageal reflux disease (GERD), elevated blood pressure readings without diagnoses of hypertension, pacemaker placement, and osteoporosis. On November 18, 2025, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-C provide blood pressure monitoring on R3, with a	0 730		

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0 730	Continued From page 12 result of 83/40 millimeters of mercury (mmHg). R3's Service Agreement dated October 29, 2022, noted R3 received services including assistance with medication administration. On November 20, 2025, at 1:40 p.m., clinical nurse supervisor (CNS)-A stated staff are expected to report low blood pressure readings to the registered nurse, but this had not been done. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	01060		

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01060	Continued From page 13 (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative for one of one resident (R3) who was hospitalized. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01060		

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01060	Continued From page 14 The findings include: R3's diagnoses included gastro-esophageal reflux disease (GERD), elevated blood pressure readings without diagnoses of hypertension, pacemaker placement, and osteoporosis. On November 17, 2025, at 12:45 p.m., licensed assisted living director (LALD)-B stated she had been providing emergency relocation notices to the Office of Ombudsman for Long-Term Care if a resident had not returned to the facility within four days, but had not been providing them to the resident, legal representative, and designated representative as required. On November 18, 2025, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-C provide blood pressure monitoring on R3, with a result of 83/40 millimeters of mercury (mmHg). R3's Service Agreement dated October 29, 2022, noted R3 received services including assistance with medication administration. R3's Progress Notes included the following: - September 8, 2025, R3 was sent to the emergency department; - September 9, 2025, R3 had been admitted to the hospital; and - September 10, 2025, R3 was discharged from the hospital. R3's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider;	01060		

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01060	Continued From page 15 - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls;	01370		

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01370	Continued From page 16 (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care services for one of one unlicensed personnel (ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01370		

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01370	Continued From page 17 During the entrance conference on November 17, 2025, at 9:40 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they were aware of the required contents of the employee records. ULP-D was hired on June 25, 2025, to provide direct care services to residents of the facility. ULP-D's record lacked documented evidence of the following: - standby assistance techniques and how to perform them; and - medication, exercise, and treatment reminders. On November 20, 2025, at 9:40 a.m., CNS-A stated this training had not been provided. The licensee's Required Training for All Employees, Minnesota - Assisted Living policy dated June 11, 2025, noted training and competency would include standby assistance techniques and how to perform them, and medication, exercise, and treatment reminders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status;	01380		

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01380	Continued From page 18 (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care services for one of one unlicensed personnel (ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 17, 2025, at 9:40 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they were aware of the required contents of the employee records. ULP-D was hired on June 25, 2025, to provide	01380		

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01380	Continued From page 19 direct care services to residents of the facility. ULP-D's record lacked documented evidence of the following: - range of motion and positioning. On November 20, 2025, at 9:40 a.m., CNS-A stated this training had not been provided. The licensee's Required Training for All Employees, Minnesota - Assisted Living policy dated June 11, 2025, noted training and competency would include standby assistance techniques and how to perform them, and medication, exercise, and treatment reminders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01530		

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01530	Continued From page 20 (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel/ULP-D) received the required amount of mental illness and de-escalation training within the required time frame. In addition, the licensee failed to ensure one of three employees (ULP-D) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01530		

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01530	Continued From page 21 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility held an assisted living license effective August 1, 2025. During the entrance conference on November 17, 2025, at 9:40 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they were aware of the required contents of the employee records. ULP-D was hired on June 25, 2025, to provide direct care services to residents of the facility. ULP-D's record lacked documented evidence of the following: - training in mental illness and de-escalation by July 1, 2025; and - the required eight hours of initial dementia care training within 160 working hours of the employment start date. On November 20, 2025, at 9:40 a.m., CNS-A and LALD-B stated this training was in progress but had not been completed. The licensee's Required Training for All Employees, Minnesota - Assisted Living policy dated June 11, 2025, noted training and competency would include eight hours of dementia training including an explanation of Alzheimer's disease and related disorders,	01530		

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01530	Continued From page 22 assistance with activities of daily living, problem solving with challenging behaviors, communication skills, and person-centered planning and service delivery. It noted the training must be completed within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and	01620		

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01620	Continued From page 23 (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 90 days after the last assessment for two of four residents (R2, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a	01620		

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01620	Continued From page 24 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's diagnoses included diabetes and high cholesterol. R2's Service Plan Report dated June 30, 2025, indicated R2 received services including assistance with bathing, dressing, and medication management. R2's record contained assessments as follows: - June 6, 2025; - June 25, 2025; and - October 21, 2025 (28 days over 90 days). On November 19, 2025, at 11:25 a.m., clinical nurse supervisor (CNS)-A stated the 90 day assessment on October 21, 2025, was late. R4 R4's diagnoses included major depressive disorder, osteoporosis, collapsed vertebra, and weakness. R4's Service Agreement dated February 14, 2024, indicated R4 received medication management services. R4's record contained assessments as follows: - February 20, 2025; - April 28, 2025; and - August 9, 2025 (13 days over 90 days). On November 19, 2025, at 11:45 a.m., CNS-A	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30309	A. BUILDING: _____ B. WING _____	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-WOODLAND	200 BUFFALO HILLS LANE BRAINERD, MN 56401

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01620	Continued From page 25 stated the 90 day assessment on August 9, 2025, was late, and she was behind on assessments. The licensee's Resident Assessment policy dated June 13, 2025, noted residents would be assessed to ensure resident health concerns were addressed in a timely manner. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and	01650		

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01650	Continued From page 26 (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included hypokalemia (low potassium), weakness, and atrial fibrillation (rapid irregular heartbeat). R1's Service Agreement and Service Plan Report dated October 29, 2025, indicated R1 received services including assistance with bathing and medication administration. However, it lacked the following: - schedule of monitoring assessments of the resident to include a nursing assessment prior to the date on which a prospective resident executes a contract with the facility or the date on which a prospective resident moves in, which	01650		

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01650	Continued From page 27 ever is earlier, and with a change of condition; - methods of monitoring staff providing services; - a contingency plan including: - names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On November 19, 2025, at 11:03 a.m., clinical nurse supervisor (CNS)-A stated the service plan lacked the above required content for R1, and added all service agreements used lacked the schedule of monitoring assessments and the methods of monitoring staff providing services. R2 R2's diagnoses included diabetes and high cholesterol. R2's Service Plan Report dated June 30, 2025, indicated R2 received services including assistance with bathing, dressing, and medication management. However, it lacked the following: - schedule of monitoring assessments of the resident to include a nursing assessment prior to the date on which a prospective resident executes a contract with the facility or the date on which a prospective resident moves in, which ever is earlier, and with a change of condition; - methods of monitoring staff providing services; and - a contingency plan including:	01650		

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01650	Continued From page 28 - names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. On November 19, 2025, at 11:25 a.m., CNS-A stated the service plan lacked the above required content. R3 R3's diagnoses included gastro-esophageal reflux disease (GERD), elevated blood pressure readings without diagnoses of hypertension, pacemaker placement, and osteoporosis. R3's Service Agreement dated October 29, 2022, noted R3 received services including assistance with medication administration. However, it lacked the following: - schedule of monitoring assessments of the resident to include a nursing assessment prior to the date on which a prospective resident executes a contract with the facility or the date on which a prospective resident moves in, which ever is earlier, and with a change of condition; - methods of monitoring staff providing services; and - a contingency plan including: - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On November 20, 2025, at 1:40 p.m., CNS-A stated the service plan lacked the above required content.	01650		

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01650	Continued From page 29 R4 R4's diagnoses included major depressive disorder, osteoporosis, collapsed vertebra, and weakness. R4's Service Agreement dated February 14, 2024, indicated R4 received medication management services. However, it lacked the following: - schedule of monitoring assessments of the resident to include a nursing assessment prior to the date on which a prospective resident executes a contract with the facility or the date on which a prospective resident moves in, which ever is earlier, and with a change of condition; - methods of monitoring staff providing services; and - a contingency plan including: - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On November 19, 2025, at 11:45 a.m., CNS-A stated R4's service plan lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have	01700		

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01700	Continued From page 30 a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment to determine what medication management services would be provided and how the services would be provided, for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01700		

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01700	Continued From page 31 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 17, 2025, at 10:20 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the residents at the facility. R1 R1's diagnoses included hypokalemia (low potassium), weakness, and atrial fibrillation (rapid irregular heartbeat). R1's Medication Information Instruction Attestation dated October 29, 2024, noted "This medication education was conducted face to face with the resident and/or responsible person and education was provided on medications including instructions regarding interventions to manage the resident's medications and prevent diversion of medications." R1's Service Agreement and Service Plan Report dated October 29, 2025, indicated R1 received services including assistance with bathing and medication administration. On November 19, 2025, at 11:03 a.m., clinical nurse supervisor (CNS)-A stated the medication assessment lacked documented evidence of the indications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. CNS-A stated the same	01700		

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01700	Continued From page 32 form was utilized for all residents. R2 R2's diagnoses included diabetes and high cholesterol. R2's Medication Information Instruction Attestation dated June 12, 2025, noted "This medication education was conducted face to face with the resident and/or responsible person and education was provided on medications including instructions regarding interventions to manage the resident's medications and prevent diversion of medications." R2's Service Plan Report dated June 30, 2025, indicated R2 received services including assistance with bathing, dressing, and medication management. On November 19, 2025, at 11:25 a.m., CNS-A stated the medication assessment lacked documented evidence of the indications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R3 R3's diagnoses included gastro-esophageal reflux disease (GERD), elevated blood pressure readings without diagnoses of hypertension, pacemaker placement, and osteoporosis. R3's Medication Information Instruction Attestation dated October 6, 2024, noted "This medication education was conducted face to face with the resident and/or responsible person and education was provided on medications including instructions regarding interventions to manage the resident's medications and prevent diversion of medications."	01700		

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01700	Continued From page 33 R3's Service Agreement dated October 29, 2022, noted R3 received services including assistance with medication administration. On November 18, 2025, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R3. On November 20, 2025, at 1:40 p.m., CNS-A stated the medication assessment lacked documented evidence of the indications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R4 R4's diagnoses included major depressive disorder, osteoporosis, collapsed vertebra, and weakness. R4's Service Agreement dated February 14, 2024, indicated R4 received medication management services. R4's Medication Information Instruction Attestation dated April 28, 2025, noted "This medication education was conducted face to face with the resident and/or responsible person and education was provided on medications including instructions regarding interventions to manage the resident's medications and prevent diversion of medications." On November 19, 2025, at 11:45 a.m., CNS-A stated the medication assessment lacked documented evidence of the indications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. No further information was provided.	01700		

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01700	Continued From page 34 TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment annually for two of four residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on November 17,	01710		

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01710	Continued From page 35 2025, at 10:20 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the residents at the facility. R1 R1's diagnoses included hypokalemia (low potassium), weakness, and atrial fibrillation (rapid irregular heartbeat). R1's Service Agreement and Service Plan Report dated October 29, 2025, indicated R1 received services including assistance with bathing and medication administration. R1's prescriber orders dated October 22, 2024, included one iron supplement (anemia) and one magnesium supplement. R1's Medication Information Instruction Attestation (medication assessment) was dated October 29, 2024. On November 19, 2025, at 11:03 a.m., clinical nurse supervisor (CNS)-A stated the medication assessment was overdue. R3 R3's diagnoses included gastro-esophageal reflux disease (GERD), elevated blood pressure readings without diagnoses of hypertension, pacemaker placement, and osteoporosis. R3's Service Agreement dated October 29, 2022, noted R3 received services including assistance with medication administration. R3's prescriber orders dated February 6, 2025, included one vitamin D3 supplement, one	01710		

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01710	Continued From page 36 diuretic, one insulin injection (diabetes), and one antidepressant. On November 18, 2025, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R3. R3's Medication Information Instruction Attestation dated October 6, 2024, noted "This medication education was conducted face to face with the resident and/or responsible person and education was provided on medications including instructions regarding interventions to manage the resident's medications and prevent diversion of medications." On November 20, 2025, at 1:40 p.m., CNS-A stated the medication assessment was overdue. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication	01730		

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01730	Continued From page 37 management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current individualized medication management plan to include all required content for four of four residents (R1, R2, R3, R4).	01730		

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01730	Continued From page 38 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 17, 2025, at 10:20 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the residents at the facility. R1 R1's diagnoses included hypokalemia (low potassium), weakness, and atrial fibrillation (rapid irregular heartbeat). R1's Service Agreement and Service Plan Report dated October 29, 2025, indicated R1 received services including assistance with bathing and medication administration. R1's prescriber orders dated October 22, 2024, included one iron supplement (anemia) and one magnesium supplement. R1's record lacked a medication management plan to include the type of medication storage system and procedures for staff to notify the registered nurse (RN) when problems arose. On November 19, 2025, at 11:03 a.m., clinical nurse supervisor (CNS)-A stated the above	01730		

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GOOD SAMARITAN SOCIETY-WOODLAND	200 BUFFALO HILLS LANE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 39 required content had not been documented for R1. R2 R2's diagnoses included diabetes and high cholesterol. R2's Service Plan Report dated June 30, 2025, indicated R2 received services including assistance with bathing, dressing, and medication management. R2's prescriber orders dated June 17, 2025, included one statin (cholesterol) and one calcium supplement. R2's record lacked a medication management plan to include procedures for staff to notify the RN when problems arose. On November 19, 2025, at 11:25 a.m., CNS-A stated the above required content had not been documented for R2. R3 R3's diagnoses included gastro-esophageal reflux disease (GERD), elevated blood pressure readings without diagnoses of hypertension, pacemaker placement, and osteoporosis. R3's Service Agreement dated October 29, 2022, noted R3 received services including assistance with medication administration. R3's prescriber orders dated February 6, 2025, included one vitamin D3 supplement, one diuretic, one insulin injection (diabetes), and one antidepressant. On November 18, 2025, at 8:03 a.m., the	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30309	A. BUILDING: _____ B. WING _____	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-WOODLAND	200 BUFFALO HILLS LANE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 40 surveyor observed unlicensed personnel (ULP)-C administer medications to R3. R3's record lacked a medication management plan to include procedures for staff to notify the RN when problems arose. On November 20, 2025, at 1:40 p.m., CNS-A stated the above required content had not been documented for R3 R4 R4's diagnoses included major depressive disorder, osteoporosis, collapsed vertebra, and weakness. R4's Service Agreement dated February 14, 2024, indicated R4 received medication management services. R4's prescriber orders dated April 21, 2025, included one antidepressant, one blood thinner, and one diuretic. R4's record lacked a medication management plan to include the type of medication storage system and the person responsible for monitoring medication supplies and refills. On November 19, 2025, at 11:45 a.m., CNS-A stated the above required content had not been documented for R4 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30309	A. BUILDING: _____ B. WING _____	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-WOODLAND	200 BUFFALO HILLS LANE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01830	Continued From page 41	01830		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to renew prescriptions at least every 12 months for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked an annual renewal of all prescriber orders for medications. R1's diagnoses included hypokalemia (low potassium), weakness, and atrial fibrillation (rapid irregular heartbeat). R1's Service Agreement and Service Plan Report dated October 29, 2025, indicated R1 received services including assistance with bathing and medication administration. R1's prescriber orders dated October 22, 2024, included one iron supplement (anemia) and one	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30309	A. BUILDING: _____ B. WING _____	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-WOODLAND	200 BUFFALO HILLS LANE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01830	Continued From page 42 magnesium supplement. On November 19, 2025, at 11:03 a.m., clinical nurse supervisor (CNS)-A stated R1's prescriber orders were overdue for the annual renewal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications for one of ten residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30309	A. BUILDING: _____ B. WING _____	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-WOODLAND	200 BUFFALO HILLS LANE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 43 On November 18, 2025, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R3, including Capzasin cream (topical pain reliever). The expiration date was September 2025. On November 18, 2025, ULP-C stated she had not checked the expiration date because the cream was new. On November 20, 2025, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated staff were expected to and trained to check medications for expiration date prior to administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: This immediate correction order was amended to include information for R1, R2, R3 on November 26, 2025. Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30309	A. BUILDING: _____ B. WING _____	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-WOODLAND	200 BUFFALO HILLS LANE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 44 two of two residents (R4, R1) with hospital-style bed rails, and for two of two residents (R2, R3) with consumer bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). This practice resulted in an immediate order for correction on November 19, 2025. The findings include: HOSPITAL BED RAILS R4 On November 18, 2025, at 2:25 p.m., the surveyor observed R4 in her bed. R4 was positioned on her left side and was able to move independently. R4's bed was a hospital style bed with a bed rail on the right side of the bed. R4's diagnoses included major depressive disorder, osteoporosis, collapsed vertebra, and weakness. R4's Service Agreement dated February 14, 2024, indicated R4 received medication management services. R4's Nursing Assessment and Level of Care Evaluation (NALOCE) dated August 9, 2025, noted R4 was independent with mobility and transferring in and out of bed. It noted no risk of falls. The August 9, 2025, assessment was R4's	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30309	A. BUILDING: _____ B. WING _____	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-WOODLAND	200 BUFFALO HILLS LANE BRAINERD, MN 56401

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02310	Continued From page 45 most current assessment. On November 19, 2025, at 9:20 a.m., clinical nurse supervisor (CNS)-A stated they were not aware R4 had a bed rail, and it must have been brought in by hospice. CNS-A contacted the hospice agency and found the bed rail had been delivered on October 23, 2025, the day after R4 admitted to hospice services. On November 19, 2025, at 11:45 a.m., CNS-A stated they were not aware of the bed rail being placed on R4's bed, and an assessment with the required content had not been completed. CNS-A stated she did not feel R4 was safe to use the bed rail, and had assessed her today, during the survey, and had the bed rail removed. CNS-A added she had talked with R4 and the responsible party who agreed to remove the bed rail. On November 19, 2025, at 12:55 p.m., unlicensed personnel (ULP)-F stated she had been trained to notify nursing if a resident had a new bed rail. On November 19, 2025, at 1:00 p.m., ULP-C stated she was trained to notify the nurse if a resident had a new bed rail, if there was an issue with a bed rail, or if there were any change related to the use of a bed rail. R4's record lacked a comprehensive assessment of the hospital-style bed rail to include R4's cognitive and physical status, the intended purpose of the bed rail, R4's risk for falls or entrapment, incontinence, pain, uncontrolled body movement, the ability to transfer in and out of bed independently, whether the bed rail was considered an improper restraint, measurements,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30309	A. BUILDING: _____ B. WING _____	11/20/2025

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GOOD SAMARITAN SOCIETY-WOODLAND	200 BUFFALO HILLS LANE BRAINERD, MN 56401

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02310	Continued From page 46 and the risk versus benefits of the bed rail. R1 On November 18, 2025, at 2:05 p.m., the surveyor observed R1 in his room. R1 stated he utilized his bed rail for getting in and out of bed, and showed the surveyor how he utilized them by getting in and out of bed. R1's diagnoses included hypokalemia (low potassium), weakness, and atrial fibrillation (rapid irregular heartbeat). R1's Service Agreement and Service Plan Report dated October 29, 2025, indicated R1 received services including assistance with bathing and medication administration. R1's NALOCE dated November 12, 2024, noted R1 was independent with mobility and transferring, and utilized the bed rail to reposition in bed. R1's Uniform Assessment Review dated August 18, 2025, noted "I have reviewed all components of the Uniform Assessment as required and there have been no changes in the resident's condition." R1's Evaluation for Assist Grab Bars dated November 15, 2024, noted the measurement for zone 1 (the area within the rails) ranged between 2.5 to 3.5 inches, and zone 2 (under the rail, between the rail supports or next to a single rail support) was less than 2 3/8 inches. However, it lacked the actual measurements for zone 2, zone 3 (between the rail and mattress) and zone 4 (under the rail, at the ends of the rail). On November 19, 2025, at 11:03 a.m., clinical	02310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-WOODLAND	200 BUFFALO HILLS LANE BRAINERD, MN 56401

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02310	Continued From page 47 nurse supervisor (CNS)-A stated R1's assessment lacked the condition and description of the bed rail and whether the bed rail was considered an improper restraint. CONSUMER RAILS R2 R2's diagnoses included diabetes and high cholesterol. R2's Service Plan Report dated June 30, 2025, indicated R2 received services including assistance with bathing, dressing, and medication management. R2's Nursing Assessment and Level of Care Evaluation dated June 25, 2025, noted R2 was incontinent of bladder, was independent with mobility, and independent with transferring in and out of bed. R2's Uniform Assessment Review dated October 1, 2025, noted the bed rails safety review had been completed and the Consumer Product Safety Commission had been checked for recalls. On November 19, 2025, at 11:25 a.m., CNS-A stated the assessment lacked the condition and description of the assistive device and whether it was considered an improper restraint. R3 R3's diagnoses included gastro-esophageal reflux disease (GERD), elevated blood pressure readings without diagnoses of hypertension, pacemaker placement, and osteoporosis. R3's Service Agreement dated October 29, 2022, noted R3 received services including assistance	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30309	A. BUILDING: _____ B. WING _____	11/20/2025

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GOOD SAMARITAN SOCIETY-WOODLAND	200 BUFFALO HILLS LANE BRAINERD, MN 56401

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02310	Continued From page 48 with medication administration. R3's Bed Rail/Side Rail Installation Check List - Assisted Living dated March 30, 2023, noted R3 utilized a M-Rail device. R3's Nursing Assessment and Level of Care Evaluation dated March 21, 2025, noted R3 was independent with mobility, was incontinent of bladder, and utilized an assistive device to reposition in bed. On November 18, 2025, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R3. On November 20, 2025, at 1:40 p.m., CNS-A stated the assessment lacked the condition and description of the assistive device and whether it was considered an improper restraint. The licensee's Assist Grab Bar Use policy dated August 20, 2025, indicated the nurse would assess bed rails for proper installation, intent, risk for entrapment, pain, incontinence, and uncontrolled body movement. It also noted the nurse would measure the bed rail to ensure it met the FDA recommendations. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body	02310		

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02310	Continued From page 49 movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30309	A. BUILDING: _____ B. WING _____	11/20/2025

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02310	Continued From page 50 the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Good Samaritan Socety Woodland
200 BUFFALO HILLS LANE
Brainerd, MN 56401
Crow Wing County
Parcel:

Phone:
ldilley4@good-sam.com

License Info

License: HFID 30309

Risk:
License:
Expires on:
CFPM: TINA M GANGSTAD
CFPM #: 32571; Exp: 1/25/2027

Inspection Info

Report Number: F1037251182
Inspection Type: Full - Single
Date: 11/17/2025 Time: 11:54:08 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 5-200A Plumbing: approved materials/design

5-201.11A *Priority Level: Priority 1 CFP#: 51*

MN Rule 4626.1040A Provide a plumbing system that is designed, constructed, installed, and repaired with approved materials, equipment, and devices complying with chapter 4714 and Minnesota Statutes, sections 326B.43 to 326B.49.
COMMENT: PORCELAIN HANDWASHING SINK WAS BROKEN AT THE TIME OF INSPECTION. REPLACE BROKEN SINK WITH APPROVED SINK. EMPLOYEE STATED THAT A SINK WAS ORDERED A COUPLE WEEKS AGO AND WILL BE INSTALLED UPON RECEIPT.

Comply By: 12/17/2025 Originally Issued On: 11/17/2025

Food & Beverage General Comment

DISCUSSED BARE HAND CONTACT, EMPLOYEE ILLNESS RECORDING, MENU, AND ORDER. BARE HAND CONTACT FACT SHEET LEFT ONSITE.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F1037251182 from 11/17/2025

RANDI HATCHER

Michelle Hovanes,
Public Health Sanitarian 2
320-223-7307
michelle.hovanes@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

Good Samaritan Socety Woodland
Brainerd
County/Group: Crow Wing County

Inspection Info

Report Number: F1037251182
Inspection Type: Full
Date: 11/17/2025
Time: 11:54:08 AM

Food Temperature: Product/Item/Unit: NOODLES**; Temperature Process:** Hot-Holding
Location: Steam Table at 173 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SPAGHETTI SAUCE**; Temperature Process:** Hot-Holding
Location: Steam Table at 168 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: RUEBEN SANDWICH**; Temperature Process:** Hot-Holding
Location: Steam Table at 154 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: DICED CUCUMBER**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK CARTON**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: PACKAGED CUT LETTUCE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESECAKE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

Good Samaritan Socety Woodland
Brainerd
County/Group: Crow Wing County

Inspection Info

Report Number: F1037251182
Inspection Type: Full
Date: 11/17/2025
Time: 11:54:08 AM

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** Wiping Cloth Bucket
Location: Prep Area **Equal To** 272 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 50 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1037251182

Food Establishment Inspection Report

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

No. of Risk Factor/Intervention/Violations	0	Date: 11/17/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:54:08 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Good Samaritan Socety Woodland	200 BUFFALO HILLS LANE	Brainerd, MN	56401	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30309		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	IN	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	N/A	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51	X	Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Michele L Hanson

Follow-up: Follow-up Date: