Electronically Delivered

March 11, 2025

Licensee
Good Samaritan Society - Bethany
1953 7th Street South
Brainerd, MN 56401

RE: Project Number(s) SL30420016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 29, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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.

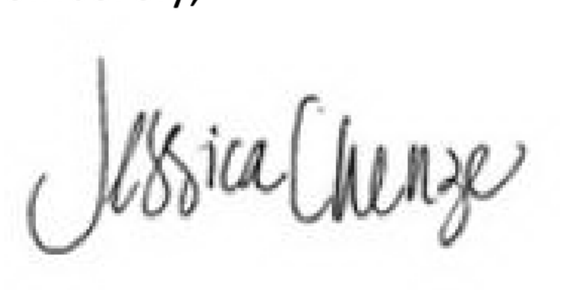
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

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0 000	Initial Comments 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: SL30420016-0 On January 27, 2025, through January 29, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 37 residents; 31 receiving services under the assisted living facility license.	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.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 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 ensure infection control standards were followed for one of two employees, (unlicensed personnel (ULP)-E) during medication administration. 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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally or in a limited number of locations). The findings include: On January 27, 2025, at 11:45 a.m., the surveyor observed ULP-E wash hands and donned (put on) disposable gloves, completed assistance with noon blood glucose (blood sugar) and insulin administration for R3 and removed disposable gloves. The surveyor did not observe ULP-E	0 510		

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0 510	Continued From page 2 wash hands after removing gloves. On January 27, 2025, at 11:55 a.m., ULP-E stated ULP-E did not need to wash hands or use hand sanitizer after removing gloves. ULP-E stated she was trained by the registered nurse (RN) who was no longer working at the facility. On January 29, 2025, at 11:35 a.m., RN-C stated expectations for handwashing include before donning and removal of gloves, as well as entering and leaving a residents apartment. RN-C stated hand hygiene was part of the ULP training. The licensee's Infection Prevention: Hand Hygiene policy, dated March 29, 2022, indicated staff to use hand sanitizer or soap and water to clean hands: - when entering patient room; - before preparing or administering medications; - if gloves are used to perform a clean/aseptic procedure, hand hygiene must be completed before donning gloves; - after removing gloves regardless of task completed to wash hands before applying gloves to both hands, dispose of used gloves in proper receptacle and rewash hands; and - when exiting patient room. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	0 800		

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0 800	Continued From page 3 systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. 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) 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: On January 27, 2025, at 11:25 a.m., the surveyor toured the facility with director of maintenance (DM)-D. During the tour, the surveyor observed the following: 1. There was a small hole in the wall behind the laundry room door on the second floor. 2. Extension cords were used to provide power in resident rooms 110 and 305, creating a fire hazard. 3. The kitchen stove was used for the storage of combustibles in resident room 305, creating a fire	0 800		

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0 800	Continued From page 4 hazard. 4. One side of the bifold closet was off the track in the bedroom of resident room 110. 5. Light bulbs were not working in one ceiling light fixture in the corridor on the first floor. 6. The labeled fire door was held open with a wedge for resident room 102. The room was not occupied at the time of the tour. Devices used to hold open fire doors must not prohibit the required operation and closing feature of the door. During the tour interview, DM-D verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	0 810		

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0 810	Continued From page 5 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. 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) 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: On January 27, 2025, administrator (A)-B and director of maintenance (DM)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN On January 27, 2025, at 11:25 a.m., the surveyor toured the facility with DM-D. During the tour, the surveyor observed a fire plan with procedures for residents posted by the elevator on the main	0 810		

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0 810	Continued From page 6 floor. The licensee failed to maintain the FSEP fire plan procedures for residents evident by the following: During an interview on January 27, 2025, at 1:25 p.m., A-B explained the resident evacuation procedures in the event of a fire. The verbal procedures did not match the written procedures in the fire plan posted by the elevator. A-B stated the resident procedures had changed but the written plan had not been updated yet. A-B verified the FSEP required revision. The licensee failed to maintain all parts of the FSEP as readily available evident by the following: On January 27, 2025, at 1:25 p.m., the surveyor requested FSEP procedures that included the individualized unique needs of residents for movement and evacuation or relocation during a fire or similar emergency. These procedures were not included in the Emergency Preparedness Binder where the FSEP was stored. A-B stated these procedures would be emailed to the surveyor by the end of the day. On January 27, 2025, at 3:15 p.m., A-B emailed the surveyor "Attached you will find a vulnerability assessment that we complete for move ins for the Fire Safety and Evacuation Plan. Anyone on services this gets put into PCC, anyone not on services it gets put into their Admission file. For residents that need assistance there is a spreadsheet hung up by the fire panel for all staff to know who needs assistance during an evacuation." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 7 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of one (unlicensed personnel (ULP)-E). 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	01440		

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01440	Continued From page 8 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: ULP-E was hired on November 30, 2021, to provide direct care services to residents at the assisted living facility. On January 27, 2025, at 11:45 a.m., the surveyor observed ULP-E assist R3 with administration of noon insulin. ULP-E's employee record lacked documentation of a registered nurse (RN) supervising ULP-E performing delegated tasks within 30 days of beginning work with the licensee. On January 29, 2025, at 11:42 a.m., RN-C stated a 30-day evaluation should have been completed on ULP-E. RN-C stated RN-C was not sure what was done prior to her working at the facility. The licensee's Nursing Services policy revised in March 2021, indicated a ULP must be supervised by an RN within 30 days after the individual begins working for the home care provider and thereafter as needed based on performance. The requirement also applies to staff that have not performed delegated tasks for one year or longer. It is the responsibility of the RN staff to ensure the supervision is done within the times frames outlined above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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. (e) 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 ongoing assessments not to exceed 90-calendar days from the last assessment for three of three residents (R1, R2, 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	01620		

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01620	Continued From page 10 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 January 27, 2025, at 10:00 a.m., registered nurse (RN)-C stated ongoing assessments were done every 90 days and change of condition assessments would be conducted on residents for instances such as change in services, or a change in condition. R1 R1's diagnoses included diabetes and congestive heart failure (weakened heart condition). R1's service plan revised on December 31, 2024, indicated R1 received medication administration. R1's records indicated 90-day assessments was completed on September 20, 2024, and December 30, 2024, which exceeded the 90 days from the last assessment (101 days in between assessments). R2 R2's diagnoses included hypertension (high blood pressure) and hyperlipidemia (high cholesterol). R2's service plan revised on October 18, 2024, indicated R2 received medication administration, laundry, and housekeeping. R2's record indicated 90-day assessments was completed on September 20, 2024, and December 30, 2024, which exceeded the 90 days	01620		

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01620	Continued From page 11 from the last assessment (101 days in between assessments). R3 R3's diagnoses included hypertension and diabetes. R3's service plan revised on October 18, 2024, indicated R2 received medication administration, laundry, and housekeeping. R3's record indicated the last 90-day assessment for R3 was completed on April 17, 2024. No additional assessments were available in R3's record. On January 29, 2025, at 10:30 a.m., RN-C stated the 90-day assessments had been late due to the clinical nurse supervisor (CNS) leaving. RN-C stated RN-C and another RN had been filling in to get assessments caught up. The licensee's Comprehensive Assessment schedule policy revised August 2022 indicated the RN will complete the following comprehensive assessment every 90 days or changes in condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=E	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	01650		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH 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
01650	Continued From page 12 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 (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 observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of three 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	01650		

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01650	Continued From page 13 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 January 27, 2025, at 10:00 a.m., registered nurse (RN)-C stated the RNs develop and maintain the service plans. R1 R1's diagnoses included diabetes and congestive heart failure (weakened heart condition). On January 28, 2025, at 6:55 a.m., the surveyor observed unlicensed personnel (ULP)-G complete R1's scheduled morning medication administration, blood glucose and apply TED stockings for R1. R1's 90-day Uniform Assessment Review dated December 30, 2024, indicated no changes to monitoring blood sugar glucose checks three or more times a day. R1's electronic medication administration record (EMAR) dated January 2025, indicated R1 received blood glucose checks three times a day and apply/remove TED stockings daily. R1's service plan revised on December 31, 2024, indicated R1 received medication administration. R1's service plan lacked the description of service to be provided, the fee for service, the frequency of the service, and the identification of staff or categories of staff who will provide the service regarding R1's blood glucose checks and TED stockings.	01650		

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01650	Continued From page 14 R3 R3's diagnoses included hypertension and diabetes. On January 27, 2025, at 11:45 a.m., the surveyor observed ULP-E complete R3's noon blood glucose and insulin administration R3's 90-day Uniform Assessment Review dated July 26, 2024, indicated no changes to monitoring blood glucose checks one to two times daily. R3's EMAR dated January 2025, indicated R2 received blood glucose checks three times a day. R3's service plan revised on October 18, 2024, indicated R2 received medication administration, laundry, and housekeeping. R3's service plan lacked the description of service to be provided, the fee for service, the frequency of the service, and the identification of staff or categories of staff who will provide the service regarding R3's blood glucose checks. On January 29, 2025, at 9:35 a.m., registered nurse (RN)-C stated R1's blood glucose and TED stockings was not on R1's service plan, and R3's blood glucose was not on R3's service plan. RN-C stated RN-C and another RN has been auditing records since the last RN left employment to make sure the resident records are correct and have all the required information. The licensee's Service Plan policy revised September 2023, indicated all residents receiving services would have a service plan in place and would include the following elements: -description of the home care services to be	01650		

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01650	Continued From page 15 provided, the fees for services (including any change to the providers fee for services), and the frequency of each service, according to the residents current review or assessment and clients preferences; -identification of the type of staff (RN/licensed practical nurse (LPN), therapist, unlicensed personnel, Home Health Aide (HHA), etc) that will provide the services; and -frequency of sessions of supervision and type of personnel who will supervise staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures. 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	01880		

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01880	Continued From page 16 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 January 27, 2025, at 10:00 a.m., registered nurse (RN)-C stated the licensee provided medication management services to residents at the facility. On January 27, 2025, at 2:05 p.m., the surveyor observed the medication refrigerator with RN-C. RN-C stated the current medication refrigerator temperature was 40 degrees Fahrenheit (F). RN-C stated the evening and night shift recorded the temperature, however, RN-C stated the temperature log should be hanging on the refrigerator and RN-C and stated it was missing. The medication refrigerator contained the following medications: -two unopened Fiasp 100 units/milliliter (ml) insulin pens for R3; and -two unopened Tresiba 100 units/ml insulin pens for R3. On January 27, 2025, at 3:00 p.m., RN-C stated a new January 2025 temperature log must not have been posted on the medication refrigerator. RN-C stated until December 22, 2024 the residents kept extra medications in the apartment refrigerators. RN-C and surveyor observed the following recorded temperatures, all recorded within the 36-46 degrees F. - December 2024, four of ten temperatures were recorded; and, - January 2025, three temperatures out of 26 days were handwritten on the bottom of the December log.	01880		

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01880	Continued From page 17 The manufacturer's instructions for Fiasp dated June 2023, indicated to store unopened Fiasp in the refrigerator at 36 degrees F to 46 degrees F. The manufacturer's instructions for Tresiba dated July 2022, indicated to store unopened Tresiba in the refrigerator at 36 degrees F to 46 degrees F. The licensee's Medication Administration and Supporting Process policy revised September 13, 2024 , indicated medications are stored at dispensing pharmacists/manufacturers instructions for temperature, light and humidity. The temperature of the medication refrigerator will be monitored daily. Temperature requirement is 36-46 degrees F. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 ensure medications were labeled with the expiration date for time sensitive medications for one of two residents	01890		

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01890	Continued From page 18 (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: During the entrance conference on January 27, 2025, at 10:00 a.m., registered nurse (RN)-C stated the licensee provided medication management services to the residents. On January 27, 2025, at 11:45 a.m., the surveyor observed unlicensed personnel (ULP)-E unlock R3's secured medication cupboard and retrieve R3's opened Fiasp 100 units/milliliter (ml) pen. The surveyor observed a pharmacy label on the insulin pen with an open date of January 20, 2025, however the pen lacked an expiration date. ULP- E stated there was no expiration date on the insulin pen and did not know when the insulin pen would expire. ULP-E stated she would need to ask the nurse about the expiration date. ULP-E did not call the nurse. On January 29, 2025, at 11:42 a.m., RN-C stated the ULPs were expected to label insulin pens with open and expiration dates when insulin pens are opened. RN-C stated she did not receive a call from ULP-E about R3's Fiasp insulin pen expiration date. The manufacturer's instructions for Fiasp dated	01890		

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01890	Continued From page 19 July 2022, indicated to discard opened insulin pens after 28 days even if the insulin pen still has insulin left in it. The licensee's Medications & Treatments: Storage and Expiration Grid revised March 2021, indicated once insulin is opened, vial/pen expires four weeks (28 days) after opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced	01910		

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01910	Continued From page 20 by: Based on interview and record review, the licensee failed to document in the resident's record the required content on disposition of the medications for one of one resident (R1) upon discharge. 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 undated Discharged Resident/Client Roster indicated R4 was admitted to the facility on November 29, 2017, and was discharged on November 25, 2024, due to death. R4's November 2024, Medication Administration record indicated R4 was administered the following medications: -pregabalin 150 milligrams (mg) daily used to treat pain; -dexamethasone 2 mg twice daily used to treat nausea; -acetaminophen 1000 mg twice daily used to treat pain; -atropine sulfate 1% two drops my mouth every 3 hours as needed (PRN) for secretions; -bisacodyl rectal suppository every 24 hours PRN for constipation; -haloperidol lactate oral concentrate 2 mg/milliliter (ml) 0.5 ml every six hours PRN for anxiety; -haloperidol 1 mg every 6 hours PRN for anxiety;	01910		

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01910	Continued From page 21 -loperamide 2 mg every 6 hours PRN for loose stools; -lorazepam 0.5 mg every 6 hours PRN for shortness of breath; -morphine sulfate oral solution 20 mg/ml 0.25 mg every 3 hours PRN for moderate pain; -morphine sulfate powder every 3 hours PRN for pain -prochlorperazine maleate 10 mg every 6 hours PRN for nausea; and -oxycodone 5 mg every 3 hours PRN for moderate pain. R4's Resident Discharge Summary dated November 25, 2024, indicated R4 passed away and medications destroyed in community following policy. R4's hospice clinical notes dated November 25, 2024, indicated assisted living facility (ALF) nursing staff to destroy medications. R4's record lacked documentation of the disposition of the above medications to include the medication name, strength, quantity, prescription numbers as applicable, to whom the medications were given, date of disposition, and names of staff or other individuals involved in the deposition. On November 27, 2024, at 12:35 p.m., registered nurse (RN)-C and administrator (A)-A stated RN-C and A-A were unable to locate R4's disposition of medication summary. RN-C stated the past clinical nurse supervisor (CNS) was working at the time and CNS was no longer employed at the facility. A-A stated there was not a pattern of medications missing when CNS was employed by facility, however, A-A stated she was not following through with her duties and was no	01910		

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01910	Continued From page 22 longer employed due to this reason. The licensee's Disposition of Medication policy dated November 8, 2024 indicated the disposition of medications must be documented when a resident is discharged or expires to demonstrate the medications were disposed of according to regulatory requirements. Destruction: in the case of controlled, non-controlled, dropped, outdated and/or discontinued medications that need to be destroyed the following procedure will be used: 1. Non-controlled medications will be destroyed by a licensed nurse and another witness, or according to state regulations. Signatures will be required of those individuals involved in the destruction. 2. Controlled medications will be destroyed by two nurses, a nurse and pharmacist or a nurse and senior living manager as allowed by state regulations. Signatures will be required of those individuals involved in the destruction. 3. If medications are destroyed in the ALC (assisted living community), and depending on whether the medication is a controlled substance or non-controlled, destruction will be documented on the Individual Resident's Narcotic Record (GSS [facility name] #247) or the Medications Destruction Log - Non-Controlled (GSS #247 B) respectively. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of	01940		

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01940	Continued From page 23 ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R1, R3) who had treatments or therapies managed by the licensee. This practice resulted in a level two violation (a	01940		

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01940	Continued From page 24 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 January 27, 2025, at 10:00 a.m., registered nurse (RN)-C stated the licensee provided treatment management services, including blood glucose checks and compression (TED) stockings to residents at the facility. R1 R1's diagnoses included diabetes and congestive heart failure (weakened heart condition). R1's 90-day Uniform Assessment Review dated December 30, 2024, indicated no changes to monitoring blood sugar glucose checks three or more times a day. R1's electronic medication administration record (EMAR) dated January 2025, indicated R1 received blood glucose checks three times a day and apply/remove TED stockings daily. R1's service plan revised on December 31, 2024, indicated R1 received medication administration, however, lacked R1 received blood glucose checks and TED stockings. On January 28, 2025, at 6:55 a.m., the surveyor observed unlicensed personnel (ULP)-G	01940		

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01940	Continued From page 25 complete R1's scheduled morning medication administration, blood glucose and apply TED stockings for R1. R3 R3's diagnoses included hypertension and diabetes. R3's 90-day Uniform Assessment Review dated July 26, 2024, indicated no changes to monitoring blood glucose checks one to two times daily. R3's EMAR dated January 2025, indicated R2 received blood glucose checks three times a day. R3's service plan revised on October 18, 2024, indicated R2 received medication administration, laundry, and housekeeping, however lacked R3 received blood glucose checks. On January 27, 2025, at 11:45 a.m., the surveyor observed ULP-E complete R3's noon blood glucose and insulin administration. R1 and R3's 's record lacked a treatment plan including the following required information regarding blood glucose checks and R1's TED stockings: -written statement of the treatment or therapy that would be provided; -documentation of specific resident instructions relating to the treatment; -identification of treatment or therapy task that would be delegated to ULPs; -procedures for notifying a RN when a problem arose with the treatment; and -resident-specific requirements relating to documentation of treatment or therapy received, verification that all treatment or therapy was administered as prescribed, and monitoring of	01940		

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GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

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01940	Continued From page 26 treatment or therapy to prevent possible complications or adverse reactions. On January 29, 2025, at 9:35 a.m., RN-C stated R1's record lacked an individualized treatment plan to include blood glucose checks and TED stockings and specific instructions. Additionally, RN-C stated R3's record lacked an individualized treatment plan for blood glucose checks. The licensee's revised Medications and Treatment policy dated March 2021, indicated the licensee would develop and maintain a current individual medication and treatment management plan based on the residents assessment. There must be an individualized treatment plan that includes the following: -a statement of the type of services that would be provided, this is included on the service plan and is signed by the resident; -documentation of specific resident instructions relating to the treatment or therapy administration, a therapy/treatment instruction is located in the client's apartment or in their chart; -identification of treatment or therapy tasks that would be delegated to unlicensed personnel, this information is identified on the service agreement; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -all treatment/therapy to be administered as prescribed and documented. The treatment or therapy management record must be current and updated when there are any changes or reviewed during 90-day supervisory visits. Changes to be documented on service agreement, service schedule, and progress note is to be recorded in resident record.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH 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
01940	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=F	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: 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 with regards to safely storing oxygen for three of three residents (R2, R6, R7). 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: On January 27, 2025, from 2:14 p.m. through 2:30 p.m., the surveyor and registered nurse (RN)-C observed the following residents rooms	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30420	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

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02310	Continued From page 28 who received assisted living services who used oxygen. R2, R6 and R7 had oxygen tanks in their rooms and all lacked a posted oxygen sign on their doors: -R2, no oxygen sign posted, five large secured tanks; -R6, no oxygen sign posted, nineteen large tanks secured, two small and three medium tanks unsecured; and -R7, no oxygen sign posted, five secured large tanks, one large unsecured tank laying on its side. On January 27, 2025, at 2:30 p.m., RN-C stated all tanks should be securely stored and resident should have signs indicating oxygen was in the resident;s room. The licensee's Oxygen Safety policy dated January 8, 2024, indicated in the senior living community (SLC) it is common to have residents who require continuous or intermittent oxygen in use. While the resident has this right, there are safety measures that both the resident and SLC need to adhere to for accident prevention. Cylinders must be stored in state or manufacturer approved storage containers to prevent them from tipping over. All appropriate signage and or placards will be displayed according to state and local regulations. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - BETHA	1953 7TH STREET SOUTH BRAINERD, MN 56401

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02310	Continued From page 29 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164
651-201-4500

Type: Full
Date: *01/27/25*
Time: 11:00:04
Report: 1037251021

Food and Beverage Establishment Inspection Report

Location:
Good Samaritan Society - Betha
1953 7th Street South
Brainerd, MN56401
Crow Wing County, 18

Establishment Info:
ID #: 0039375
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188291407
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: PORTIONED PACKAGED SALAD DRESSING
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

DISCUSSED MENU, BARE HAND CONTACT, EMPLOYEE ILLNESS RECORDING, AND MENU. ALL DISHES ARE WASHED IN AND ALL FOOD IS PREPARED AND SENT FROM THE LICENSED NURSING HOME KITCHEN IN ADJACENT BUILDING FOR IMMEDIATE SERVICE. COOLING FACT SHEET AND BARE HAND CONTACT FACT SHEET LEFT ONSITE.

Type: Full
Date: *01/27/25*
Time: 11:00:04
Report: 1037251021
Good Samaritan Society - Betha

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1037251021 of 01/27/25.

Certified Food Protection Manager: TINA GANGESTAD

Certification Number: 4556 Expires: 01/25/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
MICHELLE KING

Signed: Michelle L Hovanes
Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037251021

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 01/27/25
Time In 11:00:04
Time Out

Establishment	Address	City/State	Zip Code	Telephone
Good Samaritan Society - Betha	1953 7th Street South	Brainerd, MN	56401	2188291407

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0039375		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight	
2	IN OUT N/A	Certified food protection manager, duties	
Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting	
4	IN OUT	Proper use of reporting, restriction & exclusion	
5	IN OUT	Procedures for responding to vomiting & diarrheal events	
Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use	
7	IN OUT N/O	No discharge from eyes, nose, & mouth	
Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed	
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed	
10	IN OUT	Adequate handwashing sinks supplied/accessible	
Approved Source			
11	IN OUT	Food obtained from approved source	
12	IN OUT N/A N/O	Food received at proper temperature	
13	IN OUT	Food in good condition, safe, & unadulterated	
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction	
Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected	
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized	
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food	

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

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) 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" 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	IN OUT N/A	Pasteurized eggs used where required	
31		Water & ice obtained from an approved source	
32	IN OUT N/A	Variance obtained for specialized processing methods	
Food Temperature Control			
33		Proper cooling methods used; adequate equipment for temperature control	
34	IN OUT N/A N/O	Plant food properly cooked for hot holding	
35	IN OUT N/A N/O	Approved thawing methods used	
36		Thermometers provided & accurate	
Food Identification			
37		Food properly labled; original container	
Prevention of Food Contamination			
38		Insects, rodents, & animals not present	
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 & used		
46	Gloves used properly		
Utensil 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	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 & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 01/27/25

Inspector (Signature) Michelle L Hoversos