DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 18, 2025

Administrator
GOOD SAMARITAN SOCIETY - MAPLEWOOD
550 ROSELAWN AVENUE EAST
SAINT PAUL, MN 55117

RE: CCN: 245221

Cycle Start Date: August 26, 2025

Dear Administrator:

On November 10, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 8, 2025

Administrator
GOOD SAMARITAN SOCIETY - MAPLEWOOD

550 ROSELAWN AVENUE EAST
SAINT PAUL, MN 55117

RE: CCN:245221
Cycle Start Date: August 26, 2025

Dear Administrator:

On August 26, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 26, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by

the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 26, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101

Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
E0000	Initial Comments On 8/25/25 through 8/28/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		09/16/2025
F0000	INITIAL COMMENTS On 8/25/25 through 8/28/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed, no citations written related to complaints investigated. 1122820 H52212766C MN00111680 1122819 H52212767C MN00111316 1122818 H52212768C MN00110587 1122812 H52212770C MN00108629 1122811 H52212771C, MN00108196 1122810 H52212769C MN00109979 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been	F0000		09/16/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
F0000	Continued from page 1 attained.	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident specific advanced directive	F0578	Annual survey 8/25/2025-8/28/2025 Center: Good Samaritan Society-Maplewood Team Leaders: Administrator, DNS & QA nurse/lead Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F -0578 Request/Refuse/Discontinue Treatment Formite Advanced Directives Based on interview and document review, the facility failed to ensure the resident specific advanced directive orders were accurately reflected throughout the medical record for 1:1 resident (R75) investigated for advanced directives. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident R75, has been assessed for accurate advanced directive orders throughout the Medical Record as well as both face sheet banner in PCC and resident's POLST. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have been reviewed for accurate advanced directive orders throughout the Medical Record face sheet banner in PCC and resident's POLST this was completed on 8/29/2025. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur?	10/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
F0578 SS = D	Continued from page 2 orders were accurately reflected throughout the medical record for 1 of 1 resident (R75) investigated for advanced directives (AD). R75's face sheet (undated) indicated diagnoses of wedge compression fracture of the T11-T12 vertebra, congestive heart failure (CHF), and chronic kidney disease (CKD). R75's Brief interview of Mental Status (BIMS) assessment dated 8/22/25, indicated intact cognition. R75's Functional Ability Assessment dated 8/19/25, indicated R75 required assistance from staff with most activities of daily living (ADL) and mobility. R75's physician's orders indicated the following:-8/20/25 advanced directive DNR-8/21/25 attempt CPR R75's face sheet banner in Point Click Care (computer program) indicated code status (Advance Directive) of Do Not Resuscitate (DNR) and to attempt Cardiopulmonary Resuscitation (CPR). R75's Physician's Order for Life Sustaining Treatment (POLST) dated 8/21/25, indicated to attempt CPR. During interview on 8/25/25 at 3:18 p.m. R75 stated he wanted a "good faith attempt" at life saving measures, if he was found to be unresponsive/emergency situation. He further stated his AD should not be DNR. During interview on 8/26/25 at 8:57 a.m., registered nurse (RN)-C stated the first place they would look for code status (if a resident became unresponsive) would be on the POLST but it can also be found on the face sheet banner. RN-C verified they would have given him CPR because that is what the POLST indicated, however they further verified the face sheet banner in PCC indicated both CPR and DNR and stated that was confusing and could lead to error. During interview on 8/26/25 at 9:52 a.m. licensed practical nurse (LPN)-A stated if a resident was found unresponsive, the first place they would look for code status would depend on their location. If they were on their computer, they would look on the face sheet banner in PCC. If they were closer to the POLST book, they would look at the POLST. "There are lots of places you could look." LPN-A further stated if there was a discrepancy, they would use the code status on the face sheet banner in PCC because that "is the most accurate." During interview on 8/26/25 at 10:23 a.m., RN-D stated if a resident was found unresponsive, the first place they would look for code status was on the face sheet banner in PCC because that is the most accurate. During a follow up interview on 8/26/25 at 1:08 p.m., the surveyor showed LPN-A R75's face sheet banner in PCC which indicated both CPR and DNR and asked what they would do in that situation. LPN-A stated they would look at the actual orders and if they contained both orders, then they would get clarification from the nurse practitioner (NP). LPN-A stated she would not give direction to other staff	F0578	Continued from page 2 The DNS or designee will provide reeducation to all licensed staff, on the GSS Advanced Directives Policy. Re education will be completed by 10/3/2025. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? DNS or designee will conduct audits at approximately 7-9 per week, to ensure accurate advanced directives are reflected throughout the Medical Record and on the facesheet.. Audits will be completed weekly for one month, Audit results will be brought to monthly QAPI committee for input on the need to increase, decrease or until the QAPI committee determines substantial compliance. 5. What is the date of completion? 10/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
F0578 SS = D	Continued from page 3 regarding what action to take while she waited for direction from the NP. During interview on 8/28/25 at 9:56 a.m., the director of nursing (DON) stated if a resident was found unresponsive, the first-place nurses should look for the code status would depend on the nurse's location. If their computer was up and running, they should look on the face sheet banner in PCC, if they are closer to the desk they should look in the POLST book. After reviewing R75's face sheet banner in PC, DON stated as R75 had both DNR and CPR listed, she would look down in the orders and if there still was a discrepancy she would look in On-Base (computer program) to look at the POLST. The DON also stated this could cause a delay in R75 receiving CPR. The facility policy regarding advanced directives dated 12/2/24, was received but didn't address the first place to look for a resident's code status.	F0578		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure range of motion (ROM) was completed according to therapy recommendations for 1 of 1 resident (R4) reviewed for ROM. Findings include: R4's admission Minimum Data Set (MDS) dated 7/14/25,	F0688	F-Tag F0688 Increase/Prevent Decrease in ROM/Mobility Based on observation, interview, and document review, the facility failed to ensure range of motion (ROM) was completed according to therapy recommendations for 1 of 1 resident R4 reviewed for ROM. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident R4 has been assessed for appropriate Passive Range of Motion program. Passive Range of Motion was completed for up to 2 times per week according to the care plan and IDT recommendation and documented appropriately for R4. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have been reviewed to ensure range of motion programs have been completed and documented appropriately. This was completed on 8/28/25. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? DNS or designee will provide re-education to all licensed nurses on appropriate completion of ROM program and documentation. DNS/designee will also review facility policy on Restorative Nursing Care, Implementation and screening. Re-education will be	10/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
F0688 SS = D	Continued from page 4 indicated R4's cognition was not assessed. R4 had impairment of upper and lower extremities on both sides and was dependent on staff for all mobility, transfers, and all activities of daily living (ADL), R4's MDS indicated R4 had received physical therapy (PT) and occupational therapy (OT) and zero minutes of restorative nursing to include active and passive range of motion (PROM). R4 did not exhibit rejection of care behaviors and had diagnoses including cerebral infarction (stroke), cognitive communication deficit, and quadriplegia (paralysis affecting all limbs). R4's care plan dated 7/30/25, indicated R4 had a need for restorative intervention due to limited mobility and required passive ROM to bilateral upper and lower extremities and neck with restorative nursing. R4's PT treatment encounter note dated 8/13/25, indicated, "Patient appears at max functional potential at this time and recommendation for transition from PT to RNP [restorative nursing program] for LE [lower extremity] ROM program and caregiver training completed with both RNP staff and family for successful program with goal to prevent contractures and maintain joint integrity." R4's PT discharge summary dated 8/13/25, indicated, "Caregiver training completed with daughter/spouse and RNP staff for carryover program on unit for B [bilateral] LE PROM." R4's therapy communication to nursing staff form dated 7/29, indicated, "FMP [functional maintenance program] for PROM for LE [lower extremity] exercises at least 3x/wk [three times a week]." An additional therapy communication form dated 7/29/25, indicated, "OT FMP: RN [restorative nurse] Please perform PROM for neck & Bilateral UE's [upper extremities] at least 3x/week." R4's nursing care sheet dated 8/25/25, lacked evidence R4 required ROM. R4's 30-day lookback task report printed 8/27/25, indicated ROM on bilateral upper and lower extremities and neck was completed one time, refused twice and not applicable twice.	F0688	Continued from page 4 completed by 10/3/2025 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur. DNS or designee will conduct audits to ensure appropriate completion of Range of Motion programs and documentation. Audits will be completed at approximately 7-9 weekly for one month. Audit results will be brought to the monthly QAPI committee for input on the need to increase/decrease or QAPI committee determines substantial compliance. 5. What is the date of completion? 10/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
F0688 SS = D	Continued from page 5 During interview on 8/25/25 at 3:40 p.m., family member (FM)-A stated R4 was supposed to be receiving PROM exercises from staff but that was not happening. R4 indicated, by shaking head side-to-side, staff was not completing PROM. During interview on 8/26/25 on 2:13 p.m., nursing assistant (NA)-A stated residents residing on TCU (transitional care unit) did not typically receive restorative nursing since they were generally still receiving therapy. NA-A stated on occasion the long term care restorative nurse aide (RNA) would ambulate or exercise with TCU residents. NA-A was not aware of any resident on TCU currently receiving restorative nursing. During interview on 8/26/25 at 2:30 p.m., director of PT and OT (DPTOT) stated therapy would notify nursing of restorative nursing recommendations using a therapy to nursing communication form. DPTOT further stated they would expect RNP to be completed as recommended. During observation on 8/27/25 at 7:24 a.m., NA-A and NA-B entered R4's room. NA-A and NA-B placed pillows under each side of R4 and under each arm. R4's head of bed was raised. NA-A offered R4 a blanket to cover her, R4 declined. PROM was not performed or offered. During interview on 8/27/25 at 8:22 a.m., registered nurse (RN)-E stated if therapy recommended RNP for someone on TCU, which was rare, it would be on a communication form and then entered into the chart as an order to be displayed and charted in the TAR (treatment administration record). During interview on 8/27/25 at 8:28 a.m., physical therapy aide (PTA) stated therapy used the communication form to notify nursing of recommended RNP. PTA further stated they completed a communication form for R4 recommending PROM to be completed since PT was discontinued. PTA stated they would expect nursing to follow through on recommendations and for R4 to receive PROM exercises at least three times a week. During interview on 8/27/25 at 10:36 a.m., NA-A stated R4 was not on a RNP and PROM was not being done. NA-A stated OT was working on positioning in R4's wheelchair and nursing focused on repositioning R4 frequently to prevent skin breakdown.	F0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
F0688 SS = D	Continued from page 6 During follow up interview on 8/27/25 at 10:47 a.m., RN-E stated if the task was not on the TAR, it was not being done. RN-E stated R4 was not receiving any restorative nursing. During interview on 8/27/25 at 11:48 a.m., RN-B stated they were not aware of anyone currently on RNP on TCU. RN-B stated nursing would have received a communication form from nursing for RNP and the task would be entered as an order to display on the TAR for nursing to complete. RN-B was not aware of a RNP for R4. During interview on 8/27/25 at 12:25 p.m., RN-A stated would receive a communication form from therapy with recommendations would be received. Recommendations would be entered on a RNA task sheet in PCC (point click care) to be documented when completed. RN-A further stated the intervention would be added to the resident's care plan. RN-A stated a RNA was scheduled five days a week so all RNPs could be completed. During interview on 8/27/25 at 1:34 p.m., director of nursing (DON) stated PROM was usually performed by RNA as part of a RNP when the resident was on LTC, and when recommended should be completed while on TCU as well. DON stated R4 should have received PROM as part of a RNP. Facility policy Restorative Nursing Care Implementation and Screening dated 11/27/24, indicated, "The goal of restorative nursing care is to attain and maintain the maximum possible independence and/or prevent rapid declines through their interventions for each resident." The policy further indicated, "The restorative nurse had the overall responsibility and accountability for the restorative program. In the event the location does not have a designated restorative nurse, the responsibility and accountability remain with the director of nursing services." The policy indicated RNA and other designated and trained staff will provide care under the supervision of the restorative nurse, therapists, or DON. Facility policy Restorative Nursing Documentation dated 7/7/25, indicated, recommendations from therapy for a RNP will be added to a resident's care plan and entered into PCC for documentation.	F0688		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary	F0812	In the Health Department Surveyor's Findings, a typo was noted in the following sentence: "A facility	10/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
F0812 SS = E	Continued from page 7 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure unpasteurized eggs were fully cooked and prepared in a manner to prevent/decrease the risk of foodborne illness. This had the potential to affect up to 40 residents residing at the facility who ate undercooked eggs weekly. Findings include: A facility invoice for the periods of 8/7/25, 8/14/25, and 8/21/2025 indicated the facility received 115 dozen whole large white eggs on each order. The invoices did not include an indication that these eggs were pasteurized (a process used to eliminate bacteria and disease-producing microorganisms in foods, such as dairy). A Shopping Cart record dated 8/27/25 at 2:00 p.m., indicated the facility had a case of medium shelled pasteurized eggs in their shopping cart. A facility invoice indicated these shelled “pasteurized” eggs had been delivered on 8/28/25. During an observation and interview on 8/25/25 at 11:41	F0812	Continued from page 7 invoice for the periods of 8/7/25, 8/14/25, and 8/21/25 indicated the facility received 115 dozen whole large white eggs on each order.” One case of whole shell eggs contains 15 dozen eggs, not 115 dozen. At the time of the surveyor’s observation, the facility had 1 case (15 dozen) of shell eggs. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The correct item number for Pasteurized Shell Eggs (15 dozen/case) has been identified on the Sysco product guide. The facility received one case of Pasteurized Shell Eggs on the 8-28-25 food delivery. Subsequently, the correct product of Pasteurized shell eggs has been ordered and received at the facility. Food/Nutrition Staff were educated on the purpose and use of pasteurized shell eggs on 8-25-25 and 8-29-25 by Sue Deal, RD,LD/Food and Nutrition Director. Food/Nutrition staff will review and acknowledge information in the facility policy “Food Handling-Food and Nutrition” by the completion date. How the facility will identify other residents having the potential to be affected by the same deficient practice: Each resident/patient who orders the choice of poached egg or fried egg (served weekly on Thursday breakfast) will be served the pasteurized eggs. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Weekly audits x 4 weeks, then Monthly audits x 3 months. Audits will be completed by the Registered Dietitian. Audit findings will be reviewed by the QAPI committee for further recommendations. Date of correction: 10-3-25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
F0812 SS = E	Continued from page 8 a.m., an unopened 15 dozen box of eggs was observed in a double-door refrigerator. There were no markings on the box to indicate the eggs had been pasteurized. The dietary manager (DM) stated these eggs were used to make poached eggs and fried eggs every Thursday for the residents' breakfast. The DM confirmed these poached and fried eggs would be undercooked and have "runny" yolks, but this was the only time eggs were served in this manner. The DM confirmed she was unable to find labeling on the box indicating the eggs were pasteurized, but would find the order invoice, as she thought they were pasteurized. On 8/26/25 at 1:55 p.m., the DM stated she found the order invoices and the eggs in the refrigerator observed on 8/25/25 were not pasteurized. The DM stated the poached and/or fried eggs facility staff had been serving on Thursdays had been unpasteurized for at least the past month but was unable to determine the exact length of time unpasteurized eggs were being served. The DM stated she would complete education with her staff to ensure pasteurized eggs were used when eggs were cooked with a runny yolk and would change the order with her supplier to ensure the facility had pasteurized whole eggs on hand. During an interview on 8/27/25 at 9:38 a.m., cook (C)-A confirmed that she helped cook eggs for breakfast service regularly. C-A stated she knew the difference between pasteurized and unpasteurized eggs, but had just not noticed the eggs were unpasteurized until it was brought up this week. C-A stated kitchen staff had been using the unpasteurized eggs to cook poached eggs with “running” yolks. C-A stated the fried eggs “sometimes had runny yolks," but not always. C-A stated approximately 40 residents consumed the poached or fried eggs on Thursdays. During an interview on 8/28/25 at 10:10 a.m., the director of food and nutrition (DFN), a registered dietician, stated she would expect staff to utilize pasteurized eggs when cooking in a manner that the yolk was still runny because of the risk of foodborne illness associated with undercooked unpasteurized eggs. The DFN stated unpasteurized eggs had been served as poached eggs, and it was possible the yolks of these were running or undercooked, but the facility residents had not had any foodborne illness associated with these eggs. The facility’s Food Handling- Food and Nutrition policy dated 6/27/25, indicated hard-cooked eggs were safe for consumption, and “runny” eggs should not be served	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
F0812 SS = E	Continued from page 9 unless they were prepared from pasteurized eggs.	F0812		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F0880	F-0880 Infection Control Based observation, interview and document review the facility failed to ensure insulin pens were stored in a manner to prevent cross-contamination in 3 out of 3 medication carts on the TCU. This deficient practice had the potential to affect all residents who required insulin administration via an insulin pen who resided in the facility. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents who receive insulin via pen have been assessed for proper storage of their pen within the medication carts, to prevent cross contamination. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents who receive insulin via pen have been assessed for proper storage of their pen within the medication carts, to prevent cross contamination. Completed 8/27/2025 What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? DNS or Designee will provide reeducation to all licensed nurses on correct storage of insulin pens to prevent cross contamination. DNS/designee will also review facility policy on the Infection Prevention and Control. Reeducation will be completed by 10/3/2025. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? DNS or Designee will conduct audits at approximately 7-9 per week, to ensure that insulin pens are properly stored to prevent cross contamination. Audits will be completed weekly for one month, Audit results will be	10/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
F0880 SS = E	Continued from page 10 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin pens were stored in a manner to prevent cross-contamination in 3 of 3 medication carts on the transitional care unit (TCU). This deficient practice had the potential to affect all residents who required insulin administration via an insulin pen who resided in the facility. Findings include: During observation and interview on 8/27/25 at 10:38 a.m., registered nurse (RN)-E was at the one of three medication carts on TCU preparing medication administration. RN-E removed an insulin pen from a plastic cup in a red tote in the bottom of the medication drawer. The plastic cup contained other insulin pens prescribed for multiple residents, no barrier noted between the pens. RN-E stated this was the way the insulin pens had always been stored after opening and stated they were all in one cup, touching each other without a barrier between.	F0880	Continued from page 10 brought to monthly QAPI committee for input on the need to increase, decrease or when QAPI committee determines substantial compliance. What is the date of completion? 10/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
F0880 SS = E	Continued from page 11 During observation and interview on 8/27/25 at 12:22 p.m., RN-F opened remaining two of three medication carts on TCU. RN-F stated there were several different resident's insulin pens together without a barrier separating the pens. RN-F stated not being aware the insulin pens should not be stored together and touching other resident's pens and that this was how they had been stored since she started working at this facility. During interview on 8/27/25, RN-A stated was not aware of an issue with insulin pens being stored together. RN-A thought they should be stored apart from other types of medication. During interview on 8/27/25 at 1:31 p.m., Infection Preventionist (IP) stated each resident's insulin pens should be separated from other resident pens. IP stated separating the pens with a barrier would prevent possible cross contamination. During interview on 8/27/25 at 1:36 p.m., director of nursing (DON) stated they were not aware insulin pens needed to be stored separated by resident or with a barrier between each resident's pen, but thought it was a good idea. Facility policy Medication: Insulin Administration, Insulin Pens, Insulin Pumps dated 9/5/24, indicated, "Contamination of these devices [insulin pens] can occur externally [even in the absence of visible blood]…resulting in the potential for transmission of blood borne pathogens when used for multiple people." Facility policy Medications: Acquisition Receiving Dispensing and Storage dated 3/4/25, indicated, "All medication will be stored in accordance with manufacturers' recommendations. Refer to [facility] Insulin Administration…" policy.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on August 26,2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Maplewood, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		09/17/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: GOOD SAMARITAIN SOCIETY MAPLEWOOD is a 2-story building with no basement. GOOD SAMARITAIN SOCIETY MAPLEWOOD was constructed at three different times. The original building was constructed in 1965 and was determined to be of Type II (111) construction. In 1967 an addition was constructed to the south of the main building and was determined to be of Type II (111) construction. In 1997 an addition was constructed to the south and west of the 1967 building and determined to be of Type II (111) construction. Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire	K0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
K0000	Continued from page 2 department notification. The facility has a capacity of 71 beds and had a census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0311 SS = A	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to the seal openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1 through 19.3.1.6). This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 08/26/2025, at 9:30 AM, observations and staff interview revealed ceiling tiles were missing in Room B9. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0311		08/27/2025
K0321 SS = F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K0321	K321- Hazardous Areas- Enclosure - How the deficiency will be corrected- Director of Environmental services installed spring hinges on the nursing storage room and replaced the door closer on the food storage room on September 9, 2025.	10/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
K0321 SS = F	Continued from page 3 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed protect hazardous areas in accordance with the Life Safety Code NFPA 101 - 2012 edition 19.3.2.1, 19.3.5.9. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 08/26/2025, at 9:20 AM, observations and staff interview revealed that there was no closure on the Nursing Storage Room and the Food Storage Room door failed to close and latch.	K0321	Continued from page 3 - How the deficiency could affect others- The deficiency affects all residents and staff. An audit of all hazardous areas will be conducted by (date) to ensure compliance with NFPA requirement - What changes were made to keep the deficiency from recurring- all storerooms of over 100 square feet have had the door closer inspected to assure the door closes completely. Training will be completed with Maintenance Staff on NFPA requirements for Hazardous Area enclosures by 10/03/2025 - How will the facility monitor the corrective action to ensure it will not recur – All doors with door closers will be inspected quarterly to ensure they are working properly. The Administrator or designee will complete audits weekly x4 monthly x 2 to ensure all hazardous area doors operate within NFPA requirements. Results of the audits will be reviewed by the QAPI committee. - The date that the deficiency will be completed by October 3, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
K0321 SS = F	Continued from page 4 An interview with the Maintenance verified this deficient finding at the time of discovery.	K0321		
K0351 SS = F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, 19.3.5.4, and 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.6.6.1. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 08/26/2025, at 9:15, it was revealed by observation that there were wires in contact with the sprinkler system at Stair B on the upper and lower level.. An interview with the Maintenance Director verified	K0351	K351- Sprinkler System - Installation - How the deficiency will be corrected- Environmental services director inspect the building for any wires that are in contact with any sprinkler piping. - How the deficiency could affect others- The deficiency affects all residents. All sprinkler pipes will be audited to ensure wires are not hanging off them by 10/03/2025. - What changes were made to keep the deficiency from recurring- The director of environmental services will monitor the running of any future wires near sprinkler piping. Training will be done by 10/03/2025 with the maintenance staff to ensure wires are not hung on the sprinkler system pipes. - How will the facility monitor the corrective action to ensure it will not recur - The Environmental services director will be responsible for maintaining this standard for all future wiring installations. The Administrator or designee will perform audits will be completed weekly x4, monthly x 2 to ensure wires are not being hung on sprinkler pipes. Results of the audits will be reviewed by the QAPI committee. - The date that the deficiency was completed- This deficient practice will be completed throughout the building by October 3, 2025	10/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
K0351 SS = F	Continued from page 5 this deficient finding at the time of discovery.	K0351		
K0353 SS = A	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 4.6, 4.7, 5.1.1.1, 5.2.1.1.1, 5.2.1.1.2, 5.3.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/26/2025, at 8:50 AM, it was revealed by a review of available documentation that no documentation was presented to confirm that the Fire Department Connections were inspected in the 1st and 2nd quarter of 2025.	K0353		08/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
K0353 SS = A	Continued from page 6 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353		
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.2, 8.4.2.3, 8.4.9, 8.4.9.1, 8.4.9.2, and 8.4.9.7. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K0918	K918- Electrical Systems- Essential Electrical Systems - How the deficiency will be corrected- Facility purchased a Midtronics PBT-100 Battery Conductance Tester. Weekly testing of the generator batteries will be conducted by 10/03/2025. - How the deficiency could affect others- This deficiency affects all residents and staff. - What changes were made to keep the deficiency for recurring- Environmental services director will test the conductance of the batteries once a week during the weekly visual inspection and recorded on the current form in the battery section as pass/fail. The maintenance staff will be trained by 10/03/2025 on the completion of generator battery testing. - How will the facility monitor the corrective action to ensure it will not recur - weekly documentation will be recorded. Audits will be completed by the Administrator or designee to ensure the weekly testing of generator batteries. Audits will be reviewed by the QAPI Committee. - The date the deficiency was completed- September 8, 2025	10/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117

(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) COMPLETION DATE
K0918 SS = F Bldg. 01	Continued from page 7 On 08/26/2025, at 9:00 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that batteries for the generator were being tested monthly by conductance or specific gravity. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0918		