



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 28, 2026

Administrator

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

RE: CCN: 245221

Cycle Start Date: August 13, 2026

Dear Administrator:

On August 13, 2026, a survey was completed at your facility by the Minnesota Department(s) 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:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us

Office: 651-201-4393 Mobile: 651-279-5602

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 13, 2026 (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 13, 2027 (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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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August 28, 2026

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

Re: State Nursing Home Licensing Orders

Event ID: 284EC6-H1

Dear Administrator:

The above facility survey was completed on August 13, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

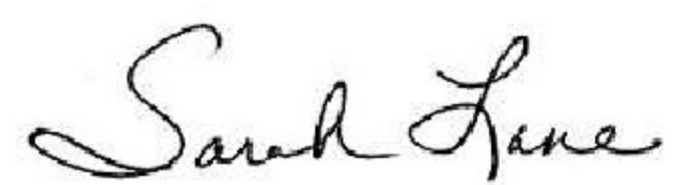
Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us

Office: 651-201-4393 Mobile: 651-279-5602

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@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 08/13/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MAPLEWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 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 8/10/26 through 8/13/26, 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			09/02/2026
F0000	INITIAL COMMENTS On 8/10/26 through 8/13/26, a standard recertification survey (S5221041) 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: H52213069C (3053151) H52213533C (3117858) H52213646C (3070852) H52213647C (2736414) NO deficiencies were cited. 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			F0000			

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 08/13/2026	
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F0000	Continued from page 1 has been attained.			F0000			09/02/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident assessments were accurate for 1 of 1 resident (R61) reviewed for dental. Findings include: R61's annual Minimum Data Set (MDS) dated 2/24/26, indicated R61 was cognitively intact and			F0641	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. F0641: Accuracy of Assessments SS: D Nursing re-assessed resident R61 for oral tissue abnormalities, pain, or immediate needs. The resident's care plan was reviewed for accurate dentition information. Point Click Care was contacted to update their software system to include "natural teeth" in the oral assessment fields (previously only included dentures). Nursing staff will undergo re-education regarding nursing assessment policies and procedures, specifically oral assessments. Five oral assessment audits will be conducted weekly for four weeks, with results presented to the Quality Assurance and Performance Improvement (QAPI) committee. All education is scheduled for completion by September 25, 2026. The Director of Nursing Services (DNS) or a designee is responsible for overseeing these tasks.		09/25/2026

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F0641 SS = D	Continued from page 2 required setup or clean-up assistance with oral hygiene. R61’s MDS did not identify any oral or dental concerns. “Obvious or likely cavity or broken natural teeth” was not checked “0-Not checked [No].” R61’s diagnoses included diabetes and chronic pain syndrome. R61’s care plan revised 7/27/26, indicated R61 had activities of daily living (ADLs) self-care performance and that R61 had her own teeth, some with crowns. R61’s HealthDrive (HD- an outside source for medical and dental support for long term care facilities) note dated 12/30/25, indicated R61 had ten missing teeth and three fractured teeth. R61’s HD note dated 5/26/26, indicated R61 was scheduled for dental appointment, but declined due to not feeling well. R61’s electronic medical record (EMR) lacked evidence of any other dental appointments. R61’s quarterly MDS nursing assessment dated 8/4/26, indicated, “Obvious or likely cavity or broken natural teeth...Not checked [No].” During observation and interview on 8/11/26 at 8:19 a.m., R61 had several teeth missing. R61 had obvious missing teeth on her upper front gumline and several scattered along her lower gumline. R61 stated she had a lot of missing teeth and at least one broken tooth on the upper and back right side. R61 stated she was hoping to get a plate for the upper front and to have the broken tooth fixed or extracted. During interview on 8/13/26 at 8:50 a.m., licensed practical nurse (LPN)-A stated quarterly or annual nursing assessments were often completed by nursing staff. LPN-A stated the MD nurse (MDS-RN) would place a nursing order to display on the resident’s treatment administration record (TAR) when the assessment was due. LPN-A stated the assessment should be a face to face assessment. During interview on 8/13/26 at 8:58 a.m., MDS-RN stated she entered a nursing order for the			F0641			09/25/2026

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F0641 SS = D	Continued from page 3 assessments per the required schedule and would expect nursing to complete the assessments accurately. MDS-RN stated she relied on the data from the nursing assessments and other documentation to code the MDS and an inaccurate assessment could cause the MDS to be coded inaccurately. MDS-RN stated an inaccurate assessment could also affect the residents care plan and ultimately the care they received. During interview on 8/13/26 at 3:59 p.m., director of nursing (DON) stated would expect nursing assessments to accurately reflect the resident's status. Facility policy Dental and Oral Care, Dental Health Assessment, Dental Services dated 3/3/26, indicated the purpose of dental assessments was to ensure "early identification and evaluation of any dental/oral health problems for treatment by a dentist or other professional to begin as early as necessary."			F0641			09/25/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in			F0657	The family of resident R61 was contacted for a care conference. Care plan was reviewed to ensure that all documentation was accurate. The facility staff addressed the turnover in the Social Work department; all current social workers have been re-educated on the requirement to document all Care Conferences and review the care plan for accuracy. The facility completed full house audited of all resident and any missed care conferences has been scheduled to be completed. The facility will audit all care conferences held over the next four weeks to ensure compliance with documentation policies and procedures, with findings to be reviewed by the QAPI committee. All tasks are scheduled for completion by September 25, 2026. The Director of Nursing Services (DNS) or a designee is responsible for overseeing these tasks.		09/25/2026

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F0657 SS = D	Continued from page 4 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure quarterly care conferences were provided or offered for 1 of 1 resident (R61) reviewed for care planning. Findings include: R61's quarterly Minimum Data Set (MDS) dated 5/26/26, indicated R61 was cognitively intact and did not exhibit rejection of care behavior. R61's diagnosis included major depressive disorder, anxiety, chronic pain, and diabetes. R61's progress note dated 5/21/25, indicated a conference occurred without R61 or a resident representative for R61 were in attendance. "Invited resident, expressed again does not want to participate in care conferences. Informed resident that facility still has to inform/invite for each care conference even if refuses. Resident verbalized understanding." R61's electronic medical record (EMR) lacked evidence any other care conference was offered, provided, or refused after 5/21/25. During interview on 8/11/26 at 8:09 a.m., R61 stated she did not always know what the plan was and could not remember attending or being offered a care conference in a long time. During interview on 8/12/26 at 2:45 p.m., social worker (SW)-A stated care conferences were documented in the EMR as a care conference note type in progress notes. SW-A verified and stated there were no care conferences documented in R61's EMR since May of 2025. SW-A stated it did not make sense that R61 would not have had a care conference since then and they should be completed quarterly. Further, R61 was due for a care conference in March and June of 2026, and that family member (FM)-A would have been invited to attend. During interview on 8/12/26 at 3:02 p.m., FM-A stated she had not been invited to or attended a care conference in over a year and did not really			F0657			09/25/2026

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F0657 SS = D	Continued from page 5 know what was going on with R61's care. FM-A further stated she felt like she was not "being kept in the loop" and that it was very frustrating. During follow up interview on 8/12/26 at 3:17 p.m., SW-A stated she thought R61 had been appropriately offered care conferences but had refused them. During interview on 8/13/26 at 3:59 p.m., director of nursing (DON) stated would expect quarterly care conferences would be completed and offered and if the resident declined to participate, the EMR would have evidence of the refusal. DON further stated care conferences were important to keep the resident and/or family members updated on the resident's plan of care. Facility policy Comprehensive Care Plan and Care Conferences dated 12/29/25, indicated, "Social worker or designated employee will...Invite residents and their representative [with resident's permission] at least two weeks in advance of the care conference...If resident and/or representative is not invited to the care conference, an explanation must be included in the medial record."			F0657			09/25/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the resident's fall interventions were in place for 1 of 1 (R9) residents reviewed for falls. Findings include: R9's Quarterly Minimum Data Set (MDS), dated 7/7/26, indicated diagnoses of dementia and end-stage renal disease (ESRD) required dialysis. R9 had intact cognition but was at risk for falls that			F0689	Resident R9 was re-educated on the importance of requesting staff assistance for safety. Skid strips were placed next to the bed per the plan of care, and instances of the resident refusing to request assistance have been formally added to the Care Plan and Kardex. The care plan was reviewed for any discrepancies. Direct care staff will receive training regarding the critical importance of following the Care Plan and Kardex, along with education on the facility's falls policy and procedure. Full house audit completed for care plan intervention for falls were cross match to be in place. Five audits of resident care plans and implemented interventions will be conducted weekly for four weeks and results will be reviewed in QAPI. All tasks are scheduled for completion by September 25, 2026. The Director of Nursing Services (DNS) or a designee is responsible for overseeing these tasks.		09/25/2026

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F0689 SS = D	Continued from page 6 required supervision with activities of daily living (ADL's), transfers and used a walker for ambulation. R9's falls assessment, dated 6/15/25, indicated she was a fall risk due to ESRD required dialysis, impulsive behavior, and impaired mobility. R9's nursing and provider orders dated 3/18/25, indicated that R9 was to be up with nursing assistance, reminded to use the call light and wait for staff assistance, and monitored through frequent safety checks each shift. R9's Safe Event Incident report dated 6/4/26, R9 was found sitting on the floor between her drawer and walker. R9 had bleeding from a forehead injury and a skin tear to her jaw and was transferred to the hospital, where she received stitches. the root cause was R9 lost her balance when she walked to her drawer to close it. The intervention following this fall included placement of skid strips next to the bed to prevent falls. R9's care plan, dated 7/8/26, indicated a self-care performance deficit related to actual falls, weakness, and impaired mobility. R9 required assistance from one staff member, a walker, and a gait belt for ambulation. R9 also required assistance from one staff member with transfers, bathing, dressing, personal hygiene, and toilet use. Additionally, R9 had dementia with decreased safety awareness and demonstrated impulsive self-transfers and self-ambulation. Interventions included restorative rehabilitation; education for R9 and family regarding fall prevention and factors that could cause falls; use of assistive devices; placement of skid strips next to the bed to prevent falls; and frequent monitoring of R9 for safety. Additionally, R9 was at risk for falls, the interventions were to provide assistance of one staff with walker during transfers and ambulation. She also had a wheelchair she could use independently. It instructed to remind R9 to use call light, wait for staff assistance, and have staff perform safety checks each shift. During an observation on 8/12/26 at 8:28 a.m., R9's room door was open. R9 was standing in the bathroom. Her walker and wheelchair were located in her room near her bed and not within arms reach. R9 independently ambulated to her wheelchair and sat down. At 8:30 a.m., R9 stood and walked to her walker. She independently ambulated with the walker to the bathroom and brushed her teeth. At 8:32 a.m., an unidentified staff member walked past R9's room but did not enter room. At 8:34 a.m., R9 was observed ambulating in room her room using her			F0689			09/25/2026

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F0689 SS = D	Continued from page 7 walker without staff present. At the same time, an unidentified staff member walked past R9's room, glanced into the room, and continued walking down the hallway. During an observation on 8/13/26 at 7:57 a.m., R9 was seated in a wheelchair in her room. R9 stood, ambulated to a recliner, and self-transferred without staff assistance or her walker which was located by the wall adjacent to the wheelchair. The call light was on recliner arm, and non-skid shoes on. At 8:01 a.m., R9 was observed ambulating in her room from the recliner to the wheelchair without a using her call light, walker or staff present. During an interview on 8/11/26 at 3:24 p.m., R9 that she walked in room by herself, self-transferred and used the bathroom independently. R9 stated that the facility did not have control over her, that she did not need to follow instructions, and that she was going to do what she wanted. During an interview on 8/12/26 at 9:17 a.m., NA-A stated that when a resident fell, staff were to notify the nurse, obtain vital signs, and remain with the resident to assist the nurse. NA-A stated that resident care was provided according to the care plan and written care sheets. During an interview on 8/12/26 at 10:13 a.m., registered nurse (RN)-D stated that when a resident fell, staff were to call for assistance and assess the resident for injuries. If the resident hit their head, neurological checks were to be performed, and the resident was monitored for a change in condition. RN-D stated that staff used a mechanical lift to elevate a resident from the floor when the assessment indicated it was appropriate. Otherwise, the resident was sent to the hospital for further treatment. RN-D stated that staff utilized the care plan and Kardex to provide the necessary care. RN-D further stated that it was important to follow provider orders for resident safety and to ensure appropriate care and progress. RN-D stated that orders were specific to each resident's care and that following the care plan was important for resident safety and autonomy. During an interview on 8/13/26 at 8:02 a.m., NA-B confirmed that R9 transferred independently and that he had observed R9 ambulating in her room without a walker or staff assistance. NA-B stated that he was unaware R9 was a fall risk. He also verified R9 used the bathroom and was walking independently. NA-B stated that he referred to the care plan when providing care to residents.			F0689			09/25/2026

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F0689 SS = D	Continued from page 8 During an interview on 8/13/26 at 8:14 a.m., RN-E stated that R9 was not supposed to self-transfer. RN-E stated that multiple-colored signs were posted on the walls of R9's room instructing her to "call, not fall," "wait for assistance", and "remember to use call light". RN-E stated that R9 had memory loss and required frequent education regarding safety and redirection. RN-E stated RN-E stated that the care plan indicated that R9 was to have skid strips placed. RN-E verified the skid strips were not present on the floor despite the care plan indicating that they were to be used to prevent falls. During an interview on 8/13/26 at 3:25 p.m., the director of nursing (DON) stated that the expectations for staff when a resident had a fall was to assess the resident for injuries and call 911 when necessary. If the fall was not serious, the resident was assessed and moved using a mechanical lift. The provider, family, and supervisor were to be notified. The fall was documented as a safe-event incident report and reviewed during the interdisciplinary team (IDT) weekly leadership meeting. The DON stated that it was important to follow orders to provide current and appropriate care for each resident. The DON stated that the care plan was designed to provide instructions for the individual resident and was updated by the DON and nurse managers. The facility's policy titled "Fall Prevention and Management," reviewed on 6/2/26, instructed staff to promote resident well-being by developing and implementing a fall prevention and management program, identifying risk factors, and implementing interventions before a fall occurred. The policy also instructed staff to provide prompt treatment after a fall occurred. A nurse was required to observe the resident and perform a full-body examination to determine whether an injury occurred, continue to monitor the resident's condition, and update the plan as needed. Staff were required to complete a safe-event incident report and fall-scene huddle worksheet and communicate that a fall had occurred to the provider, family, supervisor, during stand-up meetings, at change of shift, and through the 24-hour report.			F0689			09/25/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.			F0695	F0695 Respiratory/Tracheostomy care and Suctioning SS: D Nursing Replaced the oxygen concentrator bubbler		09/25/2026

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F0695 SS = D	Continued from page 9 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure respiratory equipment was properly maintained for 1 of 1 resident (R31) reviewed for respiratory care. Findings include: R31's quarterly Minimum Data Set (MDS) dated 5/26/26, indicated R31 was cognitively intact and required oxygen therapy. R31's diagnoses included multiple sclerosis and hypoxemia (low blood oxygen level). R31's care plan dated 5/19/26, indicated R31 had shortness of breath (SOB) related to diagnoses and required oxygen therapy. R31's August 2026, treatment administration record (TAR) indicated, "Nursing Order: Change oxygen supplies, including oxygen bubbler [container filled with water in-line with oxygen to provide humidification], and tubing. Date and initial every night shift every Wed for routine exchange and maintenance. During observation on 8/10/26 at 5:44 p.m., R31 was in bed, receiving oxygen through a nasal cannula. R31's oxygen PM bubbler was dated 6/4/26. During interview and observation on 8/10/26 at 5:54 p.m., registered nurse (RN)-A stated the oxygen tubing and bubbler was supposed to be changed weekly and confirmed R31's bubbler was dated 6/4/26 and stated it should have been changed since then. RN-A stated if oxygen supplies were not maintained properly, the chance of contracting respiratory infection increased. RN-A stated R31 required oxygen therapy for SOB and was not aware that she experienced any recent respiratory infections. During interview on 8/13/26 at 1:35 p.m., RN-B, who was also the staff educator, expected nurses to follow provider orders as written.			F0695	Continued from page 9 for resident R31. Additionally, all residents using oxygen were assessed to ensure tubing and bubblers were replaced and dated according to facility policy. The resident's care plan was reviewed for appropriate problems, goals and interventions. The facility ordered new oxygen supplies to ensure adequate stock is available. Weekly audits of all residents on oxygen and oxygen supplies will be conducted for four weeks to ensure compliance; findings will be reviewed by the QAPI committee. All nursing staff will receive education on infection control policies and procedures regarding the replacement of oxygen supplies. All tasks are scheduled for completion by September 25, 2026. The Director of Nursing Services (DNS) or a designee is responsible for overseeing these tasks.		09/25/2026

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F0695 SS = D	Continued from page 10 During interview on 8/13/26 at 3:59 p.m., director of nursing (DON) stated would expect nurses to follow orders as written and that R31's bubbler should have been changed weekly.			F0695			09/25/2026
F0880 SS = D	Facility policy Oxygen Administration, Safety, Mask Types, dated 7/16/26, indicated all oxygen equipment should be clean, safe, and functional and all disposable pieces changed weekly.						
	Infection Prevention & Control			F0880	F0880 Infection Prevention, Control		09/25/2026
	CFR(s): 483.80(a)(1)(2)(4)(e)(f)				SS:D		
	§483.80 Infection Control				Resident R73 was taken off precautions the morning after the observation. The care plan was updated to reflect discontinuation of precautions and 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.				Nurse RNC was re-educated on standard precautions; all direct care staff will be re-educated on precaution expectations, regulatory compliance, and facility policies and procedures.		
	§483.80(a) Infection prevention and control program.				Five PPE audits will be conducted weekly for four weeks and additionally all residents on precautions will be audited for proper care planning, signage and PPE weekly for four weeks with results to be shared at the QAPI meeting.		
	The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:				All tasks are scheduled for completion by September 25, 2026.		
	§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;				The Director of Nursing Services (DNS) or a designee is responsible for overseeing these tasks.		
	§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;						

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F0880 SS = D	Continued from page 11 (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 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 that the required personal protective equipment (PPE) was used for 1 of 1 resident (R73) reviewed for Contact Precautions. Findings include: R73's MDS dated 8/10/26, identified R73 was admitted on 8/4/26, was cognitively intact, and diagnoses that included congestive heart failure, heart disease, kidney problems, and recurrent Clostridioides difficile (C. difficile, a highly contagious infection spread by contact). R73's care plan dated 8/4/26, identified R73 required Contact Precautions and a private room due to C. difficile infection.			F0880			09/25/2026

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F0880 SS = D	Continued from page 12 R73's nursing progress note dated 8/10/26 at 9:53 p.m., identified R73 had active C. difficile infection. R73's nursing order dated 8/11/26, indicated R73 could be removed from isolation precautions. R73's nursing progress note dated 8/12/26 at 8:37 a.m., identified Contact Precautions were discontinued on 8/11/26, with 8/10/26 identified as the last full day of isolation. During observation on 8/10/26 at 6:02 p.m., Contact Precautions signage was posted outside R73's room and indicated all people entering the room were required to wear a gown and gloves. PPE supplies were located across the hall from R73's room. During an interview on 8/10/26 at 6:06 p.m., R73 stated staff did not always wear a gown when entering the room but usually wore gloves. R73 stated caregivers wore a gown and gloves when providing direct care. During an observation on 8/10/26 at 6:10 p.m., RN-C entered R73's room with medications without wearing a gown or gloves and touched the bedside table and interior surface of the room door. During an interview on 8/13/26 at 9:00 a.m., RN-C stated staff determine what required PPE is used by reviewing signage outside residents' rooms. RN-C verified that R73 was on Contact Precautions for C. difficile infection, as indicated by signage posted on R73's door. RN-C stated staff wear a gown and gloves when providing direct care to residents on Contact Precautions but wear only gloves when delivering medications or entering resident's rooms for non-care-related tasks. RN-C confirmed she did not wear a gown or gloves when entering R73's room because she was only delivering medications. During an interview on 8/14/26 at 4:40 p.m., the interim director of nursing (DON) confirmed staff were expected to wear a gown and gloves when entering R73's room while Contact Precautions were in place. The facility's Standard, Enhanced Barrier, and Transmission-Based Precautions policy, revised 4/30/26, identified Contact Precautions were required for residents with infections that posed an increased risk for contact transmission. The policy directed staff to put on a gown and gloves before contact with the resident or the resident's environment and to remove PPE before leaving the room.			F0880			09/25/2026

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/10/26 through 8/13/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed:			20000			09/25/2026

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 H52213069C (3053151) H52213533C (3117858) H52213646C (3070852) H52213647C (2736414). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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/RULES.			20000			09/25/2026

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20540	Comprehensive Resident Assessment CFR(s): MN Rule 4658.0400 Subp. 1 & 2 Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident assessments were accurate for 1 of 1 resident (R61) reviewed for dental.			20540	F0641: Accuracy of Assessments SS: D Nursing re-assessed resident R61 for oral tissue abnormalities, pain, or immediate needs. The resident's care plan was reviewed for accurate dentition information. Point Click Care was contacted to update their software system to include "natural teeth" in the oral assessment fields (previously only included dentures). Nursing staff will undergo re-education regarding nursing assessment policies and procedures, specifically oral assessments. Five oral assessment audits will be conducted weekly for four weeks, with results presented to the Quality Assurance and Performance Improvement (QAPI) committee. All education is scheduled for completion by September 25, 2026. The Director of Nursing Services (DNS) or a designee is responsible for overseeing these tasks.		09/25/2026

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20540	Continued from page 3 Findings include: R61's annual Minimum Data Set (MDS) dated 2/24/26, indicated R61 was cognitively intact and required setup or clean-up assistance with oral hygiene. R61's MDS did not identify any oral or dental concerns. "Obvious or likely cavity or broken natural teeth" was not checked "0-Not checked [No]." R61's diagnoses included diabetes and chronic pain syndrome. R61's care plan revised 7/27/26, indicated R61 had activities of daily living (ADLs) self-care performance and that R61 had her own teeth, some with crowns. R61's HealthDrive (HD- an outside source for medical and dental support for long term care facilities) note dated 12/30/25, indicated R61 had ten missing teeth and three fractured teeth R61's HD note dated 5/26/26, indicated R61 was scheduled for dental appointment, but declined due to not feeling well. R61's electronic medical record (EMR) lacked evidence of any other dental appointments. R61's quarterly MDS nursing assessment dated 8/4/26, indicated, "Obvious or likely cavity or broken natural teeth...Not checked [No]." During observation and interview on 8/11/26 at 8:19 a.m., R61 had several teeth missing. R61 had obvious missing teeth on her upper front gumline and several scattered along her lower gumline. R61 stated she had a lot of missing teeth and at least one broken tooth on the upper and back right side. R61 stated she was hoping to get a plate for the upper front and to have the broken tooth fixed or extracted. During interview on 8/13/26 at 8:50 a.m., licensed practical nurse (LPN)-A stated quarterly or annual nursing assessments were often completed by nursing staff. LPN-A stated the MD nurse (MDS-RN) would place a nursing order to display on the resident's treatment administration record (TAR) when the assessment was due. LPN-A stated the assessment should be a face to face assessment. During interview on 8/13/26 at 8:58 a.m., MDS-RN stated she entered a nursing order for the assessments per the required schedule and would expect nursing to complete the assessments accurately. MDS-RN stated she relied on the data			20540			09/25/2026

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20540	Continued from page 4 from the nursing assessments and other documentation to code the MDS and an inaccurate assessment could cause the MDS to be coded inaccurately. MDS-RN stated an inaccurate assessment could also affect the residents care plan and ultimately the care they received. During interview on 8/13/26 at 3:59 p.m., director of nursing (DON) stated would expect nursing assessments to accurately reflect the resident's status. Facility policy Dental and Oral Care, Dental Health Assessment, Dental Services dated 3/3/26, indicated the purpose of dental assessments was to ensure "early identification and evaluation of any dental/oral health problems for treatment by a dentist or other professional to begin as early as necessary." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20540			09/25/2026
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by:			20830	F 0689 Free of Accident Hazards/Supervision/Devices SS: D Resident R9 was re-educated on the importance of requesting staff assistance for safety. Skid strips were placed next to the bed per the plan of care, and instances of the resident refusing to request assistance have been formally added to the Care Plan and Kardex. The care plan was reviewed for any discrepancies. Direct care staff will receive training regarding the critical importance of following the Care Plan and Kardex, along with education on the facility's falls policy and procedure.		09/25/2026

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20830	Continued from page 5 Based on observation, interview, and document review, the facility failed to ensure the resident's fall interventions were in place for 1 of 1 (R9) residents reviewed for falls. Findings include: R9's Quarterly Minimum Data Set (MDS), dated 7/7/26, indicated diagnoses of dementia and end-stage renal disease (ESRD) required dialysis. R9 had intact cognition but was at risk for falls that required supervision with activities of daily living (ADL's), transfers and used a walker for ambulation. R9's falls assessment, dated 6/15/25, indicated she was a fall risk due to ESRD required dialysis, impulsive behavior, and impaired mobility. R9's nursing and provider orders dated 3/18/25, indicated that R9 was to be up with nursing assistance, reminded to use the call light and wait for staff assistance, and monitored through frequent safety checks each shift. R9's Safe Event Incident report dated 6/4/26, R9 was found sitting on the floor between her drawer and walker. R9 had bleeding from a forehead injury and a skin tear to her jaw and was transferred to the hospital, where she received stitches. the root cause was R9 lost her balance when she walked to her drawer to close it. The intervention following this fall included placement of skid strips next to the bed to prevent falls. R9's care plan, dated 7/8/26, indicated a self-care performance deficit related to actual falls, weakness, and impaired mobility. R9 required assistance from one staff member, a walker, and a gait belt for ambulation. R9 also required assistance from one staff member with transfers, bathing, dressing, personal hygiene, and toilet use. Additionally, R9 had dementia with decreased safety awareness and demonstrated impulsive self-transfers and self-ambulation. Interventions included restorative rehabilitation; education for R9 and family regarding fall prevention and factors that could cause falls; use of assistive devices; placement of skid strips next to the bed to prevent falls; and frequent monitoring of R9 for safety. Additionally, R9 was at risk for falls, the interventions were to provide assistance of one staff with walker during transfers and ambulation. She also had a wheelchair she could use independently. It instructed to remind R9 to use call light, wait for staff assistance, and have staff perform safety checks each shift.			20830	Continued from page 5 Five audits of resident care plans and implemented interventions will be conducted weekly for four weeks and results will be reviewed in QAPI. All tasks are scheduled for completion by September 25, 2026. The Director of Nursing Services (DNS) or a designee is responsible for overseeing these tasks.		09/25/2026

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20830	Continued from page 6 During an observation on 8/12/26 at 8:28 a.m., R9's room door was open. R9 was standing in the bathroom. Her walker and wheelchair were located in her room near her bed and not within arms reach. R9 independently ambulated to her wheelchair and sat down. At 8:30 a.m., R9 stood and walked to her walker. She independently ambulated with the walker to the bathroom and brushed her teeth. At 8:32 a.m., an unidentified staff member walked past R9's room but did not enter room. At 8:34 a.m., R9 was observed ambulating in room her room using her walker without staff present. At the same time, an unidentified staff member walked past R9's room, glanced into the room, and continued walking down the hallway. During an observation on 8/13/26 at 7:57 a.m., R9 was seated in a wheelchair in her room. R9 stood, ambulated to a recliner, and self-transferred without staff assistance or her walker which was located by the wall adjacent to the wheelchair. The call light was on recliner arm, and non-skid shoes on. At 8:01 a.m., R9 was observed ambulating in her room from the recliner to the wheelchair without a using her call light, walker or staff present. During an interview on 8/11/26 at 3:24 p.m., R9 that she walked in room by herself, self-transferred and used the bathroom independently. R9 stated that the facility did not have control over her, that she did not need to follow instructions, and that she was going to do what she wanted. During an interview on 8/12/26 at 9:17 a.m., NA-A stated that when a resident fell, staff were to notify the nurse, obtain vital signs, and remain with the resident to assist the nurse. NA-A stated that resident care was provided according to the care plan and written care sheets. During an interview on 8/12/26 at 10:13 a.m., registered nurse (RN)-D stated that when a resident fell, staff were to call for assistance and assess the resident for injuries. If the resident hit their head, neurological checks were to be performed, and the resident was monitored for a change in condition. RN-D stated that staff used a mechanical lift to elevate a resident from the floor when the assessment indicated it was appropriate. Otherwise, the resident was sent to the hospital for further treatment. RN-D stated that staff utilized the care plan and Kardex to provide the necessary care. RN-D further stated that it was important to follow provider orders for resident safety and to ensure appropriate care and progress. RN-D stated that orders were specific to each resident's care and that			20830			09/25/2026

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20830	Continued from page 7 following the care plan was important for resident safety and autonomy. During an interview on 8/13/26 at 8:02 a.m., NA-B confirmed that R9 transferred independently and that he had observed R9 ambulating in her room without a walker or staff assistance. NA-B stated that he was unaware R9 was a fall risk. He also verified R9 used the bathroom and was walking independently. NA-B stated that he referred to the care plan when providing care to residents. During an interview on 8/13/26 at 8:14 a.m., RN-E stated that R9 was not supposed to self-transfer. RN-E stated that multiple-colored signs were posted on the walls of R9's room instructing her to "call, not fall," "wait for assistance", and "remember to use call light". RN-E stated that R9 had memory loss and required frequent education regarding safety and redirection. RN-E stated RN-E stated that the care plan indicated that R9 was to have skid strips placed. RN-E verified the skid strips were not present on the floor despite the care plan indicating that they were to be used to prevent falls. During an interview on 8/13/26 at 3:25 p.m., the director of nursing (DON) stated that the expectations for staff when a resident had a fall was to assess the resident for injuries and call 911 when necessary. If the fall was not serious, the resident was assessed and moved using a mechanical lift. The provider, family, and supervisor were to be notified. The fall was documented as a safe-event incident report and reviewed during the interdisciplinary team (IDT) weekly leadership meeting. The DON stated that it was important to follow orders to provide current and appropriate care for each resident. The DON stated that the care plan was designed to provide instructions for the individual resident and was updated by the DON and nurse managers. The facility's policy titled "Fall Prevention and Management," reviewed on 6/2/26, instructed staff to promote resident well-being by developing and implementing a fall prevention and management program, identifying risk factors, and implementing interventions before a fall occurred. The policy also instructed staff to provide prompt treatment after a fall occurred. A nurse was required to observe the resident and perform a full-body examination to determine whether an injury occurred, continue to monitor the resident's condition, and update the plan as needed. Staff were required to complete a safe-event incident report and fall-scene huddle worksheet and communicate that a fall had occurred			20830			09/25/2026

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20830	Continued from page 8 to the provider, family, supervisor, during stand-up meetings, at change of shift, and through the 24-hour report. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies and procedures for assessing resident safety with implementing fall risk interventions. educate staff, then perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.			20830			09/25/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 08/11/2026, 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			K0000			09/25/2026

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

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR 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. 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 department notification.			K0000			09/25/2026

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K0000 Bldg. 01	Continued from page 2			K0000			09/25/2026
K0712 SS = F Bldg. 01	The facility has a capacity of 71 beds and had a census of 64 at the time of the survey.			K0712			09/25/2026
	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:						
K0712 SS = F Bldg. 01	Fire Drills			K0712	K-712-Fire Drills		09/25/2026
	CFR(s): NFPA 101						
K0712 SS = F Bldg. 01	Fire Drills			K0712	A fire drill schedule will be made by the Administrator or designee that complies with the NFPA requirements.		09/25/2026
	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.						
K0712 SS = F Bldg. 01	19.7.1.4 through 19.7.1.7			K0712	Training will be conducted with the Environmental Services Director on the NFPA requirements for fire drills.		09/25/2026
	This STANDARD is NOT MET as evidenced by:						
K0712 SS = F Bldg. 01	Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility			K0712	A fire drill schedule will be made by the Administrator or designee that complies with the NFPA requirements.		09/25/2026
	Findings include:						
K0712 SS = F Bldg. 01	On 8/11/2026 at 10:10 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 a fire drill had been completed during the First Shift and Second Shift of the Second Quarter of 2026.			K0712	Audits will be completed by the administrator or designee weekly x 4 monthly x2 to ensure the documentation for fire drills complies with NFPA requirements. Results of the audits will be reviewed by the QAPI committee.		09/25/2026
	An interview with the Environmental Services Director and the Senior Director verified this deficient finding at the time of discovery.						
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing			K0914	The annual electrical outlet inspection will be complete in accordance with NFPA requirements.		09/25/2026
	CFR(s): NFPA 101						
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing			K0914	Training will be conducted with the Environmental Services Director to ensure electrical outlet testing is completed within NFPA requirements		09/25/2026
	Hospital-grade receptacles at patient bed locations						

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K0914 SS = F Bldg. 01	Continued from page 3 and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct annual electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/11/2026, at 10:15 AM, it was revealed by a review of available documentation that the annual electrical outlet inspection had not been completed within the last year. An interview with the Environmental Services Director and the Senior Director verified this deficient finding at the time of discovery.			K0914	Continued from page 3 The annual electrical outlet inspection will be scheduled for yearly completion in TELS. Audits of the electrical outlet inspection will be completed by the Administrator or designee weekly x 4, monthly x 2. Audits will be reviewed by the QAPI committee. Substantial completion will be achieved by 9/25/2026.		09/25/2026
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			K0918	The generator schedule will be checked to ensure the generator has a visual inspection completed weekly; monthly testing of the emergency generator will be conducted under load for 30 minutes, and a 3-year 4-hour load bank test is completed. The emergency generator schedule on TELS will be checked to ensure compliance with NFPA requirements. Training will be conducted with the Environmental Services Director on the NFPA Requirements for		09/25/2026

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K0918 SS = F Bldg. 01	Continued from page 4 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 generator 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 8.3.4, and 8.4.9. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 08/11/2026 at 10:37 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 weekly generator inspections had occurred between 4/14/2026 and 6/11/2026 2. On 08/11/2026 at 10:40 AM, it was revealed by a review of available documentation that at the time of the survey, the facility was unable to provide documentation confirming that the emergency generator was tested in May 2026. 3. On 08/11/2026 at 10:42 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing a four (4) hour load bank			K0918	Continued from page 4 Essential Electrical Systems. Audits will be completed of the documentation for the essential electrical systems by the Administrator or designee weekly x 4, monthly x 2. Audits will be reviewed by the QAPI committee.		09/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/11/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MAPLEWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 550 ROSELAWN AVENUE EAST , SAINT PAUL, Minnesota, 55117			
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K0918 SS = F Bldg. 01	Continued from page 5 test has been completed within the last 36 months for the generator. An interview with the Environmental Services Director and the Senior Director verified these deficient findings at the time of discovery.			K0918			09/25/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect patient care related electrical appliances and equipment (PCREE) per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2, 10.3, and 10.5.2.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 08/11/2026 at 10:25 AM, it was revealed by a review of the available documentation that at the			K0921	The PCREE testing of Patient Care Related Electrical Equipment will be completed. The TELS program will be checked to ensure all PCREE testing is completed in accordance with NFPA requirements. Training will be completed with the Environmental Services Director on the requirements for PCFREE testing. Audits of the PCREE documentation will be completed by the Administrator or designee weekly x 4, monthly x 2. Audits will be reviewed by the QAPI committee. Substantial completion will be achieved by 9/25/2026		09/25/2026

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K0921 SS = F Bldg. 01	Continued from page 6 time of the survey, the facility could not provide documentation showing that the patient care-related electrical appliances and equipment (PCREE) in the facility had been inspected or tested. An interview with the Environmental Services Director and the Senior Director verified this deficient finding at the time of discovery.			K0921			09/25/2026
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/11/2026 at 11:09 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors near resident room 208 caused by wires. An interview with the Environmental Services Director and the Senior Director verified this deficient finding at the time of discovery.			K0372	All fire barriers will be checked for penetrations The TELS program will be checked to ensure fire barriers are checked in compliance with NFPA requirements. Training will be completed with the Environmental Services Director on the NFPA requirements for fire barriers. Audits of the fire barriers will be completed by the administrator or designee weekly x4, monthly x 2. Audits will be reviewed by the QAPI committee, Substantial completion will be achieved by 9/25/2026.		09/25/2026
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure			K0321	The door to the kitchen will be checked and adjusted to meet NFPA requirements. All hazardous area doors will be checked to ensure		09/25/2026

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K0321 SS = D Bldg. 01	Continued from page 7 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 to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/11/2026 at 11:38 AM, it was revealed by observation that the doors to the kitchen that are equipped with self-closing devices would not close			K0321	Continued from page 7 compliance with NFPA requirements. The TELS platform will be checked to ensure all hazardous area doors are tested in compliance with NFPA requirements. Audits for Hazardous Area doors will be completed by the Administrator or designee weekly x 4, monthly x 2. Audits will be reviewed by the QAPI committee. Substantial completion will be achieved by 9/25/2026.		09/25/2026

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K0321 SS = D Bldg. 01	Continued from page 8 and latch properly.			K0321			09/25/2026
K0353 SS = D Bldg. 01	An interview with the Environmental Services Director and the Senior Director verified this deficient finding at the time of discovery 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 and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. This deficient finding could have an isolated impact on the residents within the facility Findings include: On 08/11/2026 at 10:55 AM, it was revealed by observation that there was conduit resting on the sprinkler pipe above the ceiling near stairway A. An interview with the Environmental Services Director and the Senior Director verified this deficient finding at the time of discovery.			K0353	All sprinkler heads will be checked to make sure NFPA compliance is obtained. All sprinkler heads will be checked to make sure NFPA compliance is obtained. The TELS platform will be checked to ensure NFPA compliance of the fire sprinkler system is obtained. Audits will be completed of the fire sprinkler system to ensure NFPA compliance is achieved weekly x 4, monthly x2. Audits will be reviewed by the QAPI committee. Substantial completion will be achieved by 9/25/2026.		09/25/2026

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K0511 SS = D Bldg. 01	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the electrical system per NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, and NFPA 70 (2011 edition), National Electrical Code, sections 300.15 and 314.25. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/11/2026 at 11:09 AM, it was revealed by observation that there was an open junction box with uncapped wires near room 208 An interview with the Environmental Services Director and the Senior Director verified this deficient finding at the time of discovery			K0511	All Junction Boxes will be inspected to ensure NFPA compliance. All Junction Boxes will be inspected to ensure NFPA compliance. The Environmental Services Director will be trained in NFPA compliance of Utilities. Audits of the utilities and conduit will be completed weekly x 4, monthly x2. Audits will be reviewed by the QAPI committee. Substantial completion will be achieved by 9/25/2026.		09/25/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 1, 2026

Administrator

GOOD SAMARITAN SOCIETY - MAPLEWOOD

550 ROSELAWN AVENUE EAST

SAINT PAUL, MN 55117

RE: CCN: 245221

Cycle Start Date: September 30, 2026

Dear Administrator:

On September 30, 2026, 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.

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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



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Electronically delivered

October 1, 2026

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

Re: Reinspection Results
Event ID: 284EC6-H2

Dear Administrator:

On September 30, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 13, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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