Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 1, 2026

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

RE: CCN: 245221
Cycle Start Date: May 12, 2026

Dear Administrator:

On June 29, 2026, the Minnesota Department of Health 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

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July 1, 2026

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

Re: Reinspection Results
Event ID: 2312EA-H2

Dear Administrator:

On June 29, 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 May 12, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2026

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

RE: CCN:245221
Cycle Start Date: May 12, 2026

Dear Administrator:

On May 12, 2026, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 August 12, 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 November 12, 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.

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

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June 3, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 2312EA-H1

Dear Administrator:

The above facility survey was completed on May 12, 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

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 05/12/2026
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
F0000	INITIAL COMMENTS On 5/7/26, 5/8/26, 5/11/26, 5/12/26, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52211725C (2999256) with deficiencies cited at F684, F690, F755, F880. 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 that substantial compliance with the regulations has been attained.	F0000		06/22/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and documentation, the facility failed to assess and monitor non-pressure skin conditions for 2 of 3 residents	F0684	F684 – Quality of Care 1. Resident R1 was discharged. Nursing staff began completing the non-pressure skin/wound assessments for R2 and care plan was updated with interventions on 6/9. 2. All residents with non-pressure skin/wounds have the potential to be affected by the deficient practice. Specifically, all residents with non-pressure skin/wounds records were audited for weekly skin observations per policy. If a resident was found to not have assessment, DNS or designee completed skin observation and made appropriate notifications as needed. 3. To ensure systemic changes are sustained, the CLDS RN has educated the nursing staff on the facility's Skin/Wound assessment policy to include weekly assessments and documentation.	06/22/2026

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

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 05/12/2026
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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F0684 SS = D	Continued from page 1 (R1 and R2) reviewed for skin management. R1 R1's admission Minimum Data Set (MDS) dated 2/5/26, indicated R1 had intact cognition, no mood or behavior concerns, and no rejection of care. R1 required setup or clean-up assistance with eating, oral hygiene, personal hygiene; substantial/maximal assistance for upper body dressing, lower body dressing, putting on/taking off footwear, rolling left and right, sit to lying/lying to sitting on bed side, sitting to standing, chair/bed-to-chair transfers; and dependent on staff for toileting hygiene, showering, toilet transfers. R1 had an indwelling catheter and was frequently incontinent of bowel. R1's diagnoses included hypertension, benign prostatic hyperplasia (BPH), renal failure, diabetes mellitus, malnutrition, and glaucoma. R1's care plan undated, indicated R1 had diabetes mellitus and directed staff to wash feet daily with mild soap and water, dry thoroughly, and may use a light dusting of powder or lotion but not between toes. Staff were to check all body for breaks in skin and treat promptly as ordered by health care provider, inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness and report abnormalities to nurse. R1's care plan indicated R1 had cellulitis to right lower extremity and directed staff to remind resident not to scratch skin and monitor healing. R1's care plan indicated R1 had potential for pressure ulcer development due to weakness and impaired mobility. Staff were directed to educate family/resident as to causes of skin breakdown, inform family/resident of any new area of skin breakdown, provide gel foam cushion in wheelchair and pressure reducing mattress on bed, and notify nurse immediately of any new areas of skin breakdown, such as redness, blisters, bruises, and discoloration noted during bath or daily care. R1's Treatment Record March 2026, directed staff to: -2/3/26 to 3/9/26, wound care to right foot every Tuesday and Friday. Wound VAC (vacuum-assisted closure; type of therapy which uses a device to decrease air pressure on a wound) at negative 125 mmHg pressure. Cleanse with saline and pat dry. Supplies included medium black foam. -3/10/26 to 4/3/26, wound VAC to right foot wound at negative 125 mmHg pressure. Wound care every Tuesday and Friday. Cleanse with saline and pat dry. Apply Cavilon No Sting Barrier around wound. Apply	F0684	Continued from page 1 4. To ensure compliance is sustained the DNS/Designee will review three User Defined Assessments (UDA) weekly for skin assessment completion and documentation. Audit results will be brought to the monthly QAPI committee to assess the need to increase or decrease to ensure substantial compliance is achieved. 5. Completion date 6/22/26	06/22/2026

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F0684 SS = D	Continued from page 2 drape around incision. Cut strip of drape and apply to skin if bridge needed. Cut foam to fit incision. Cover foam with drape to obtain tight air seal. Cut quarter size opening where suction pad to be place. Apply suction pad. R1's Treatment Record April 2026, directed staff to: -4/5/26 to 4/9/26, cleanse right foot wound three times per week, Tuesday, Thursday, and Sunday, with normal saline or five-minute Vashe soak (medical technique used to clean wound with a solution), pat dry with non-sterile gauze, cut Hydrofera Blue READY (antibacterial foam dressing) and transfer to size of wound, cover with gauze, and secure with roll gauze and tape. The order directed staff to apply Hydrofera Blue with shiny side facing up if there was a shiny side. On 4/12/26, the order had additional direction to cover with ABD pad (an absorbent abdominal dressing) if needed for increased drainage. -Cover open area on buttocks with Mepilex (soft, absorbent silicone foam bandage) every three days on day shift, which started 4/21/26 and was discontinued on 4/23/26. -On 4/23/26, staff were directed to cleanse sacrum/buttock wound every shift and as needed for incontinence episode. The wound was to be cleansed with preferred cleanser and barrier cream was to be applied for moisture-associated skin damage. R1's progress notes dated 4/19/26, indicated "[R1] stated [left] butt hurts and looked at it and it appears as an open lesion or pressure sore." The notes indicated "measurements not documented as part of this assessment". The nurse wrote a note in "Dr. Board to order treatment for it and added it [to] the wound rounds." R1's verbal order dated 4/20/26, directed staff to cover open area of buttocks with Mepilex every day shift every three days. R1's progress notes dated 4/21/26 and 4/22/26, did not include new information related to R1's buttocks. R1's progress note dated 4/23/26 at 1:29 p.m., indicated the skin issue of the buttocks was evaluated. The area was identified as moisture-associated skin damage and acquired in-house. The area was measured as 5.41 cm	F0684		06/22/2026

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F0684 SS = D	Continued from page 3 (centimeters) by 4.11 cm and described as scabbed with fragile, dry/flaky, and intact surrounding tissue. The area was cleansed with normal saline, generic wound cleanser and barrier cream was applied. R1's Wound Evaluation and Management Summary dated 4/23/26, directed staff to apply house barrier cream every shift/three times a day and as needed if saturated, soiled, or dislodged for 30 days. The sacrum wound was classified as moisture associated skin damage with mild pain, scab, and open areas of exposed dermis. The wound size was 5.41 by 4.11 cm. During interview on 5/8/26 at 3:17 p.m., RN-A stated they addressed skin concerns according to the prompts of the medication and treatment record. RN-A recalled R1's wound to foot but not other skin concerns. RN-A stated if they had new wound concerns, they measured the area and updated the provider, wound team, and family. During interview on 5/11/26 at 3:29 p.m., the interim director of nursing (DON) and RN-D, who was also a nurse manager, reviewed R1's medical documents. They expected nursing to use descriptive words to describe a new skin concern and avoid words such as "pressure". Measurements were required if the skin concern was open. R2 R2's admission MDS dated 4/6/26, indicated R2 had intact cognition and required setup or clean-up assistance with eating and personal and oral hygiene and was dependent on staff for toileting hygiene, showering, dressing, bed and wheelchair mobility, and transfers. R2 had an indwelling catheter and was frequently incontinent of bowel. R2 had diagnoses which included atrial fibrillation, heart failure, hypertension, benign prostatic hyperplasia, urinary tract infection, renal failure, arthritis, osteoporosis, and hip fracture. R2 was at risk for pressure ulcers and had a surgical wound. R2's Clinical Admission Assessment dated 3/31/26, indicated R2 had a bruise above right elbow which measured 1 cm (centimeter) in length. R2's Skin Issues assessment dated 3/31/26, indicated R2 had bruise above right elbow and bruise at genital area with additional location information which described bruise as on his scrotal area and inner thigh. The assessment indicated "overall wound characteristics improved".	F0684		06/22/2026

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F0684 SS = D	Continued from page 4 R2’s care plan dated 4/15/26, indicated R2 had potential for pressure ulcer development and had a pressure ulcer related to weakness, impaired mobility, pulmonary edema, and acute kidney injury. The care plan instructed staff to assess, record, and monitor wound healing and report improvement and declines to the health care provider. R2’s Treatment Records April to May 2026 indicated: -4/7/26, skin check every evening shift on Tuesdays and complete skin assessment. Report any skin insults or new skin injury to nurse manager or wound team. -4/16/26, left calf wound: cleanse wound daily and as needed for loose and/or saturated dressing with saline or wound cleanser, apply silver calcium alginate cut to fit wound, cover with ABD, and secure with kerlix. -4/17/26 to 4/23/26, left dorsal foot/left heel: apply betadine daily every day shift for wounds. -4/23/26 to 5/5/26, left dorsal foot/left heel: cleanse wounds daily and as needed with saline or wound cleanser, apply betadine, cover with ABD, and secure with kerlix and tape. -4/30/26, nursing skin check every Tuesday evening and document in the assessment tab. -5/5/26, left dorsal foot/left heel/left calf: cleanse wounds every day shift and as needed for loose/saturated dressing with saline or wound cleanser, apply xeroform to wound beds, cover with ABD and secure with kerlix and tape. R2’s progress notes, which included skin issue and skilled evaluation assessment notes, indicated: -3/31/26 at 5:03 p.m., bruising above right elbow issue present on admission. The note indicated a new skin issue described as a bruising to R2’s genital, scrotal and inner thigh area. The note indicated the bruising was present on admission and was “improving.” -4/1/26 at 3:03 p.m., genital bruising on scrotal area and inner thigh issue present on admission. Bruising above right elbow issue present on admission. The note indicated a new skin issue described as a surgical wound on R2’s left lateral thigh. Sutures were noted, and “measurements not	F0684		06/22/2026

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 05/12/2026
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F0684 SS = D	Continued from page 5 documented as part of this assessment.” - 4/1/26 to 5/10/26, indicated “skin issue has not been evaluated” for R2’s genital bruising, bruising above right elbow, and surgical wound of the left lateral thigh. During observation and interview on 5/7/26 at 1:14 p.m., R2 reported no concerns about their cares. R2 had a dressing wrapper around his left foot and had no other visible skin concerns. During a follow up interview on 5/12/26 at 1:58 p.m., the DON expected staff to monitor R2’s non-pressure skin concerns through weekly skin assessments. The facility policy Skin Assessment Pressure Ulcer Prevention and Documentation Requirements- Rehab/Skilled, Therapy & Rehab dated 3/30/26, directed staff to accurately document observations and assessments of residents. The policy directed staff to record the location of the area, the measurements, and the ulcer/wound characteristics if a pressure ulcer was identified. The policy indicated skin tears, abrasions, and bruises were not intended to be recorded on the Skin Issues assessment. The policy directed staff to monitor bruises, contusions, skin tears, and abrasions weekly and document any changes and/or progress toward healing on the Skin Check assessment and on resident’s care plan.	F0684		06/22/2026
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F0690	F690 – Bowel/Bladder Incontinence, Catheter, UTI R1 was discharged. Nursing staff began monitoring and documenting R2 urine output on 5/13. R3’s characteristics of urine were assessed and reported to MD as needed. Monitoring and documentation for R3’s urine began on 5/13 along with ensuring urine bag was stored in a clean manner. 2. All residents with catheters have the potential to be affected by the deficient practice. Specifically, all current residents who have catheters will be audited for reporting, monitoring, and documentation of urine output and catheter cares, and proper storage of their catheter bags to reduce risk of infection. 3. To ensure systemic changes are sustained, the CLDS RN has educated the nursing staff on the facility’s Catheter Policy to include Monitoring, reporting and documentation requirements and safe storage.	06/22/2026

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 05/12/2026
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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F0690 SS = D	Continued from page 6 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to monitor urine output for 2 of 3 residents (R1 and R2) and failed to report, monitor, and document urine characteristics for 1 of 1 (R2) resident who was observed for staff emptying catheter bag. In addition, the facility failed to document catheter cares for 3 of 3 residents (R1, R2, and R3) and failed to store a catheter bag in a manner to reduce risk of infection for 1 of 1 resident (R3) who was observed to have a leg drainage bag during the day and larger catheter bag overnight. Findings include: R1's admission Minimum Data Set (MDS) dated 2/5/26, indicated R1 had intact cognition, no mood or behavior concerns, or rejection of care. R1 required setup or clean-up assistance with eating, oral hygiene, personal hygiene; substantial/maximal assistance for upper body dressing, lower body dressing, putting on/taking off footwear, rolling left and right, sit to lying/lying to sitting on bed side, sitting to standing, chair/bed-to-chair transfers; and dependent on staff for toileting hygiene, showering, toilet transfers. R1 had an indwelling catheter and was frequently incontinent of bowel. R1's diagnoses included hypertension, benign prostatic hyperplasia (BPH), renal failure, diabetes mellitus, malnutrition, and glaucoma. R1's hospital Discharge Summary, with admission date of 3/18/26 and discharge date of 3/23/26, indicated R1 was hospitalized for clostridium difficile colitis and catheter-associated urinary tract infection. The urine culture grew E.coli.	F0690	Continued from page 6 4. To ensure compliance is sustained the Director of Nursing (DNS)/designee will audit two catheter cares weekly. Audit results will be brought to the monthly QAPI committee to assess the need to increase or decrease to ensure substantial compliance is achieved. 5. Compliance Date 6/22/26	06/22/2026

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F0690 SS = D	Continued from page 7 R1’s care plan 4/29/26, indicated R1 had an indwelling catheter due to BPH, a urinary tract infection, and renal insufficiency due to chronic kidney disease. Staff were directed to: -Monitor/document pain/discomfort due to catheter. -Monitor for signs/symptoms (s/s) of discomfort on urination and frequency. -Monitor/record/report to health care provider for s/s urinary tract infection (UTI): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. -May wear leg bag during the day and straight catheter drainage bag at night. -Report unusual observations/conditions to nurse. -Observe and report to nurse s/s of UTI frequency, urgency, foul smelling urine, pain with urination, fever, nausea, vomiting, back pain, lower abdominal pain, blood in urine, cloudy urine, altered mental status, change in level of consciousness, loss of appetite, behavior changes. -Encourage fluid intake. -Assist, supervise, remind R1 to wash hands after toileting and before and after meals. -Monitor/document/report for signs/symptoms of acute renal failure which included urine output. R1’s progress notes reviewed between 3/1/26 to 4/26/26, indicated catheter care was provided once on 4/22/26. In review of R1’s record there was no indication catheter care had been routinely completed on other days between the review dates of 3/1/26 through 4/26/26. In review of R1’s urinary output documented between 4/15/26 to 4/25/26, the record identified inconsistent monitoring to ensure the catheter was patent or free from complications nor did the record include assessments/evaluation of accumulative daily totals of urinary output. The following was documented:	F0690		06/22/2026

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F0690 SS = D	Continued from page 8 -On 4/15/26, the record for urine output at 6:43 a.m. and 1:11 p.m. noted “response not required” and at 9:59 p.m. urine out was 550 cubic centimeters (cc; metric unit of volume) indicating a daily total of 550 cc’s. -On 4/16/26, the record for urine output at 6:33 a.m. was 1,000 cc, 10:51 a.m. was 550 cc, and 9:32 p.m. was 800 cc indicating a daily total of 2,350 cc’s. -On 4/17/26, the record for urine output at 6:34 a.m. was 1,000cc, “response not required” at 2:59 p.m., and 300 cc at 10:59 p.m. indicating a daily total of 1,300 cc’s. -On 4/18/26, the record for urine output at 6:51 a.m. was 600 cc’s. No other urine output was documented for 4/18/26. -On 4/19/26, the record for urine output at 6:41 a.m. was 2,000 cc and 575 cc at 10:59 p.m. indicating a daily total of 2,575 cc’s. -On 4/20/26, the record for urine output at 6:16 a.m. was 700 cc and 2:09 p.m. noted “response not required” indicating a daily total of 700 cc’s. -On 4/21/26, the record for urine output at 9:54 p.m. was 850 cc’s. No other urine output was documented for 4/21/26. -On 4/22/26, the record for urine output at 9:55 a.m. was 550 cc and 400 cc at 9:22 p.m. indicating a daily total of 950 cc’s. -On 4/23/26, the record for urine output at 6:33 a.m. noted “response not required” and 500 cc at 6:12 p.m. indicating a daily total of 500 cc’s. -On 4/24/26, the record for urine output at 6:10 a.m. was 850 cc and 550 cc at 10:59 p.m. indicating a daily total of 1,400 cc’s. -On 4/25/26, the record for urine output at 6:13 a.m. was 400 cc, and no other urine output was documented. R1’s physician visit dated 4/24/26 with a faxed time stamp of 4:10 p.m. identified R1 was seen for constipation and ongoing nausea and vomiting. Unable to keep solid food down, tolerates only light breakfast and liquid meals. An abdominal x-ray had been completed with negative for obstruction/constipation. The visit note did not	F0690		06/22/2026

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F0690 SS = D	Continued from page 9 address or mention urinary assessment or catheter related complications other than the mention of historic hospitalization from 3/18/26-3/23/26. R1's progress note dated 4/24/26 at 9:05 p.m. Resident seemed upset and when asked what the problem was. He complained about his foley catheter not changed yesterday. He worries about a bladder infection and hospitalization. R1's progress note dated 4/24/26 at 9:10 p.m. identified R1's vital signs and blood sugar were within normal limit. Am shift reported he had repeated emesis during the shift. No emesis was reported this shift at this time and his appetite was good. R1's progress note dated 4/24/26 at 9:15 p.m. indicated catheter was patent with clear yellow urine with no urinary complaints. R1's progress note dated 4/24/26 at 10:04 p.m. indicated urinary collection bag was not available. Foley was irrigated but resident wanted it changed. R1's record did not identify why the catheter was irrigated, if the irrigation was successful, and if R1 had discomfort as a result of the procedure. R1's progress note dated 4/25/26 at 4:38 a.m. included Resident requested to go to ER this afternoon due to severe abdominal pain after other inventions failed (interventions were not identified). Bladder residual scanned at this time was 26 ml, foley cath draining ok, urine was clear and free of sediments. Late entry progress note dated 4/26/26 at 1:11 p.m. indicated on Sunday 4/26/26 (inaccurate date as evidenced by hospital records) patients foley catheter was changed per his and resident representative request. He was complaining of bladder spasm and stated that the catheter wasn't working right, he was also bypassing urine. Patient reported the catheter was replaced by the overnight nurse. Patient then called his resident representative, and they brought in one from home and demanded that the catheter be changed right away. R1's Hospital Discharge Summary, with admission on 4/25/26 and discharge on 4/30/26, indicated R1	F0690		06/22/2026

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F0690 SS = D	Continued from page 10 had abdominal pain and urine appeared “grossly infected”. R1’s diagnosis was acute pyelonephritis (bacterial infection causing inflammation of the kidneys) associated with bilateral hydronephrosis (both kidneys swollen due to urine backup). During interview on 5/7/26 at 2:10 p.m., NA-C stated they worked with R1, and R1 had complained he could not urinate before he was sent to the hospital on 4/25/26. NA-C stated they observed R1’s catheter draining without concern and reported to nursing. NA-C stated nursing assistants documented residents’ urinary output and nurses monitored if residents had more or less urinary output. During interview on 5/7/26 at 4:21 p.m., registered nurse (RN)-C stated they sent R1 into the hospital on 4/25/26 for abdominal pain. RN-C stated R1’s catheter was changed the previous shift, and R1 had clear urine in his catheter bag. During interview on 5/11/26 at 3:29 p.m. with the interim director of nursing (DON) and RN-D, who was also the nurse manager, continence and urinary charting were reviewed. The DON stated nurse managers reviewed nursing assistant charting to ensure accuracy. RN-D stated nurses on the floor reviewed urinary outputs from catheters at the end of each shift. RN-D stated they could not articulate if there were changes in urinary output, since there were shifts in which no urinary output was documented. Staff were directed to view the care plan for direction to complete catheter care and documented if prompted to in the “tasks”. R1’s care plan and nursing assistant tasks did not direct staff to perform or document catheter cares. R2 R2’s admission MDS dated 4/6/26, indicated R2 had intact cognition and required setup or clean-up assistance with eating and personal and oral hygiene and was dependent on staff for toileting hygiene, showering, dressing, bed and wheelchair mobility, and transfers. R2 had an indwelling catheter and was frequently incontinent of bowel. R2 had diagnoses which included atrial fibrillation, heart failure, hypertension, benign prostatic hyperplasia, urinary tract infection, renal failure, arthritis, osteoporosis, and hip fracture. R2 was at risk for pressure ulcers and had a surgical wound. R2’s care plan dated 4/15/26, indicated R2 had a catheter related to BPH and urinary retention. The care plan directed the staff to:	F0690		06/22/2026

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F0690 SS = D	Continued from page 11 -Monitor/document for pain/discomfort due to catheter. -Monitor for signs/symptoms of discomfort on urination and frequency. -Monitor/record/report to health care provider for s/s UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. -May wear leg bag during the day and straight catheter drainage bag at night. -Report unusual observations/conditions to nurse. R2’s Medication, Nursing, and Treatment Records from March to May 2026, directed staff to complete the following: -Change drainage bag every Friday and as needed if plugged and unable to clear with irrigation. -Change 16 French with 10 cc (cubic centimeter) balloon as needed if dislodged or plugged and unable to clear with irrigation. R2’s progress notes dated 3/31/26 to 5/11/26, indicated catheter care was provided once on 4/3/26. R2’s Follow Up Question Report for 5/1/26 to 5/11/26, the record identified inconsistent monitoring to ensure the catheter was patent or free from complications nor did the record include assessments/evaluation of accumulative daily totals of urinary output. The following was documented: -On 5/1/26, the record for urine output at 6:39 a.m. was 700 cc, at 11:13 a.m. noted “response not required”, and 450 cc at 9:56 p.m. indicating a daily total of 1,150 cc’s. -On 5/2/26, the record for urine output at 6:05 a.m. was 700 cc for a daily total of 700 cc’s. -On 5/3/26, the record for urine output 700 at 6:38 a.m. was 700 cc and at 10:18 p.m. was 400 cc indicating a daily total of 1,100 cc’s	F0690		06/22/2026

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F0690 SS = D	Continued from page 12 -On 5/4/26, the record for urine output at 6:21 a.m. was 700 cc, at 1:52 p.m. noted “response not required”, and 700 cc at 9:58 p.m. indicating a daily total of 1,400 cc’s. -On 5/5/26, the record for urine output at 5:02 a.m. noted “response not required”, 650 cc at 10:33 a.m., and 300 cc at 9:25 p.m. indicating a daily total of 950 cc’s. -On 5/6/26, the record for urine output at 1:36 p.m. was 450 cc and at 10:35 p.m. was 450 cc indicating a daily total of 900 cc’s. During observation and interview on 5/7/26 at 2:10 p.m., NA-C wore gloves and gown to empty R2’s catheter bag. The urine had a foul smell and a darkish yellow orange color. NA-C was about to dump the urine in the toilet when surveyor asked about the urine appearance. NA-C stated the urine was a “deep yellow”, did not articulate further, and dumped urine into toilet. NA-C washed R2’s catheter tube and penial area with a soapy washcloth in the morning. Nursing assistants documented residents’ urinary output and nurses monitored if residents had more or less urinary output. During interview on 5/7/26 at 4:21 p.m., RN-C stated staff did not report any current urinary concerns to her for any resident during her shift, which included R2. RN-C stated it was important for staff to tell nursing about urinary concerns, so nursing could assess dehydration or urinary tract infections and have testing like a urinalysis and/or culture ordered. Review of R2’s record on 5/7/26 did include documentation of the noted darkish yellow/orange urine and foul odor nor a corresponding comprehensive assessment. Further no notation of catheter cares provided. R2’s urine output record did not include urine output for the day shift; On 5/7/26, the record for urine output at 10:22 a.m. was 650 cc and at 10:28 p.m. was 350 cc for indicating daily total of 1,000 cc’s. During interview on 5/8/26 at 2:17 p.m., NA-A stated they worked with R2. NA-A stated they did not have concerns with R2’s urine output and would	F0690		06/22/2026

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F0690 SS = D	Continued from page 13 chart R2's output. NA's would alert nurses If residents with a urinary catheter had no output, blood in the urine, fever, confusion, or anything unusual. During observation and interview on 5/8/26 at 4:18 p.m., NA-B stated they had not emptied R2's catheter since the evening shift started and was not sure how much was emptied from the day shift. NA-B stated they had not heard of any concerns with R2's urine. NA-B stated they washed R2's penial area and catheter tubing with soap and water in the morning and evening. NA-B documented urinary output each time the catheter was emptied and would report to a nurse if urine was red, pink, thick, or had a strong smell. NA-B entered R2's room and emptied R2's urine from catheter bag in a clear graduated container. R2's urine had a yellowish hue, tannish white particles, and a longer thick substance in the tubing as urine was emptied. NA-B stated they would report the urine appearance to the nurse and dumped the urine into the toilet. Review of R2's record on 5/8/26 did not include documentation of R2's urine integrity (yellowish hue, tannish white particles, and a longer thick substance) nor evident corresponding comprehensive assessment was completed. R2's progress note dated 5/8/26 included "urinary catheter intact". R2's urine output was documented as at 6:51 a.m. noted "response not required" and at 10:38 p.m. was 550 cc indicating a daily total of 550 cc's. No urine output was recorded for the day shift. Further no notation of catheter cares were completed and provided. R2's urine output on 5/9/26 was left blank indicating R2 did not have any urine output. R2's progress note dated 5/9/26 indicated R2's urinary catheter was "changed" per "as needed for urinary retention" order. The note did not include urine characteristics. R2's urine output on 5/10/26 identified urine output at 6:15 a.m. was 450 cc, at 2:17 p.m. was 200 cc, and at 10:59 p.m. noted "response not required" for a daily total of 650 cc. R2's progress notes dated 5/10/26 indicated R2's urinary catheter change was noted as "effective", and Skilled Evaluation note indicated "urinary catheter intact." The notes did not include urine characteristics R2's urine output on 5/11/26, at 6:23 a.m. was 800	F0690		06/22/2026

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F0690 SS = D	Continued from page 14 cc, 550 cc at 12:50 p.m., and 700 cc at 10:59 p.m. indicating a daily total of 2,050 cc’s. During interview on 5/12/26 at 10:29 a.m., RN-A stated R2’s urine usually looked yellow. RN-A stated nursing assistants should report if urine looked “deep yellow”, foul smelling, or had particles and had not heard of any recent concerns with R2’s urine. During interview on 5/8/26 at 2:52 p.m., NA-F stated they checked catheter bags for emptying needs at the beginning of their shift because sometimes the catheter bags were full, and NA-F was unsure if the morning shift emptied or not. NA-F would round on residents with urinary catheters throughout their shift and emptied when the catheter bags were full. NA-F stated they wrote down the urine amount emptied on their paper and documented the total urine output amount at the end of the shift. During interview on 5/8/26 at 3:17 p.m., RN-A stated signs and/or symptoms of urinary tract infection (UTI) included irritating, fever, burning and everyone had different UTI symptoms. RN-A stated they would assess urine, push fluids, ask providers for a urinary analysis and/or urinal culture, and document if they noticed signs and/or symptoms of a UTI. RN-A stated nursing assistants charted urinary output for residents with a catheter and let the nurses know of urinary concerns, such as lack of output. RN-A stated they observed urinary conditions throughout their shift. During interview on 5/8/26 at 3:55 p.m., RN-B stated signs and/or symptoms of UTI included confusion, pain, cloudy or red urine. RN-B stated they would assess the catheter site and ensure catheter patency if they suspected any catheter related infection. RN-B stated staff documented urine and catheter concerns in progress notes. During interview on 5/11/26 at 3:29 p.m. with the interim director of nursing (DON) and RN-D, who was also the nurse manager, continence and urinary charting were reviewed. The DON stated nurse managers reviewed nursing assistant charting to ensure accuracy. RN-D stated nurses on the floor reviewed urinary outputs from catheters at the end of each shift. RN-D stated they could not articulate if there were changes in urinary output related to the shifts in which no urinary output was documented. The nursing assistants were expected to report to nursing about urinary concerns or lack of output.	F0690		06/22/2026

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(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
F0690 SS = D	Continued from page 15 Nurses were expected to chart urinary concerns and monitor in a skilled note, progress note, or other clinical monitoring assessment. RN-D reviewed R2's notes and indicated the notes did not note any "outside findings" besides the catheter change. Staff were directed to view the care plan for direction to complete catheter care and documented if prompted to in the "tasks". R2's care plan did not direct staff to complete or document catheter cares. R3 R3's admission MDS dated 2/1/26, indicated R3 had moderate cognitive impairment and an indwelling catheter. R3 was dependent on staff with most activities of daily living and had diagnoses which included coronary artery disease, heart failure, neurogenic bladder, multiple sclerosis, and malnutrition. R3's indwelling catheter care plan dated 1/28/26, directed staff to: -Monitor/document for pain/discomfort due to catheter. -Monitor for signs/symptoms of discomfort on urination and frequency. -Monitor/record/report to health care provider for s/s UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. -May wear leg bag during the day and straight catheter drainage bag at night. -Report unusual observations/conditions to nurse. R3's care plan did not direct staff to complete or document catheter cares. R3's Medication, Nursing, and Treatment Records from March to May 2026, directed staff to complete the following: -Change drainage bag every Friday and as needed if plugged and unable to clear with irrigation. -Change foley catheter every 30 days. -Change 22 French with 5 cc (cubic centimeter) balloon as needed if dislodged or plugged and	F0690		06/22/2026

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F0690 SS = D	Continued from page 16 unable to clear with irrigation. R3's progress notes dated 3/1/26 to 5/10/26 did not indicate catheter cares were completed except on 4/27/26 and 5/1/26. During observation and interview on 5/7/26 at 12:54 p.m., a catheter bag was between two towels on a dry shower chair. NA-E placed gloves on and observed the catheter. NA-E lifted the drainage bag to observe, and the top of the catheter bag tubing, the connector port, touched the shower curtain railing. The connector port did not have a cap on it, and the catheter bag had a noticeable amount of clear yellow urine. During a follow-up interview on 5/12/26 at 11:09 a.m., NA-E stated they cleaned the outside of the overnight catheter bag with an alcohol wipe or soapy towel before storing for later use. NA-E was unsure how to rinse out the inside of the overnight catheter bag. During observation and interview on 5/12/26 at 10:56 a.m., NA-D verified there was no cap on the connector port of R3's catheter bag which was stored between two towels on a dry shower chair. NA-D verified the presence of clear yellow urine in the stored, overnight catheter bag. During interview on 5/12/26 at 10:29 a.m., RN-A stated they used to cap the connector ports of catheters bags stored during the day for later use and used to rinse out catheter bags with vinegar and water and was unsure about current cap use and rinsing practices for catheter bags. During interview on 5/11/26 at 3:29 p.m. with the interim director of nursing (DON) and RN-D, who was also the nurse manager, continence and urinary charting were reviewed. Staff were directed to view the care plan for direction to complete catheter care and documented if prompted to in the "tasks". R3's care plan and nursing assistant tasks did not direct staff to perform or document catheter cares. RN-D stated facility competency directed the staff to rinse a catheter bag. The DON and RN-D could not articulate a facility practice to cap the connector port tubing on catheter bags which were to be stored during the day or overnight for exchanges from leg to overnight/overnight to leg catheter bags. Facility policy Catheter: Care, Insertion, and Removal, Drainage Bags, Irrigation, Specimen- AL, R/S, and LTC dated 3/2/26, directed staff to	F0690		06/22/2026

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F0690 SS = D	Continued from page 17 complete catheter care in the morning and bedtime and as needed. Catheter care included: -inspect urine collection for color, clarity, and quantity. -observe urethral meatus and surrounding tissue for inflammation, encrustations, swelling, or discharge, and ask the resident if burning or discomfort is present. -provide perineal care with soap and water, peri-wash as directed or disposable wipes. -secure the catheter with the catheter securement device and secure the drainage bag and tubing below the level of the bladder. The policy directed staff to clean leg bags and straight drainage bag with warm soapy water or one part white vinegar and three parts water solution or an appropriate commercial solution by pouring solution into the bag, soak the bag for 30 minutes, drain the solution from the bag, rinse with warm water, hang to dry covered with a clean towel, and cover/cap the tubing once the bag is dry. The policy directed staff to store tubing caps in designated bag or container when not in use and clean with alcohol pad before recapping tubing. The policy directed staff to record urine volume where appropriate. The policy directed staff to note amount and character of urine and report any signification observations to licensed nurse (blood, mucus, low urine output).	F0690		06/22/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F0755	F755 – Pharmacy Services 1. Resident R1 was discharged. Facility ensured R2's medication was available and will educate staff on proper measures to take if medication is unavailable. 2. All residents have the potential to be affected by the deficient practice. DNS or designee conducted an audit of medications marked unavailable to ensure residents had access to medications and staff knew proper measures to take if medication is unavailable. Anyone found to be affected by deficiency will have corrections made. 3. To ensure systemic changes are sustained, the CLDS RN has educated the Licensed Nurses on the process of double-checking readmission orders for accuracy, availability of medications, and notifications to Pharmacy and Physician when unavailable.	06/22/2026

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F0755 SS = D	Continued from page 18 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure medications were available for administration per physician order for 2 of 3 residents (R1 and R2) reviewed for medication errors. Findings include R1's admission Minimum Data Set (MDS) dated 2/5/26, indicated R1 had intact cognition, no mood or behavior concerns, or rejection of care. R1 required setup or clean-up assistance with eating, oral hygiene, personal hygiene; substantial/maximal assistance for upper body dressing, lower body dressing, putting on/taking off footwear, rolling left and right, sit to lying/lying to sitting on bed side, sitting to standing, chair/bed-to-chair transfers; and dependent on staff for toileting hygiene, showering, toilet transfers. R1 had an indwelling catheter and was frequently incontinent of bowel. R1's diagnoses included hypertension, benign prostatic hyperplasia (BPH), renal failure, diabetes mellitus, malnutrition, and glaucoma. R1's Discharge Summary dated 3/23/26, indicated R1 admitted to the hospital 3/18/26 for clostridium difficile colitis and catheter-associated urinary tract infection. Discharge medications included fidaxomicin (an antibiotic used to treat diarrhea and kill bacteria or prevent bacterial growth) 200 mg (milligrams) by mouth twice daily for seven days for clostridium difficile bacteria. R1's hospital Medication Administration Record (MAR) dated 3/23/26 identified R1 was administered fidaxomicin at 8:00 a.m. indicating an evening dose was required.	F0755	Continued from page 18 4. To ensure compliance is sustained the DNS/Designee will monitor all newly readmitted residents MAR for any medications that were unavailable and if the Pharmacy and Physician were notified weekly. Audit results will be brought to the monthly QAPI committee to assess the need to increase or decrease to ensure substantial compliance is achieved. 5. Compliance Date 6/22/26	06/22/2026

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F0755 SS = D	Continued from page 19 R1’s admission physician orders included the order for fidaxomicin twice daily however, identified the start date for administration was on 3/24/26 and not 3/23/26. R1’s medication administration record (MAR) included the physician order for fidaxomicin and identified a start date of 3/24/26 at 8:30 a.m. The MAR identified R1did not receive the 3/23/26 evening dose. Additionally, the MAR identified the 8:30 a.m. dose was not administered and marked as “drug not available”. The MAR identified the remaining doses were administered as scheduled. R1’s progress notes 3/23/26 to 3/31/26, identified R1 returned to the facility on 3/23/26 and started antibiotic. In review of R1’s record there was no indication the physician was notified R1 missed two doses of the antibiotic and did not identify actions that were taken for the unavailable medication. R2 R2’s admission MDS dated 4/6/26, indicated R2 had intact cognition and required setup or clean-up assistance with eating and personal and oral hygiene and was dependent on staff for toileting hygiene, showering, dressing, bed and wheelchair mobility, and transfers. R2 had an indwelling catheter and was frequently incontinent of bowel. R2 had diagnoses which included atrial fibrillation, heart failure, hypertension, benign prostatic hyperplasia, urinary tract infection, renal failure, arthritis, osteoporosis, and hip fracture. R2 was at risk for pressure ulcers and had a surgical wound. R2 received one injection during the seven days of the MDS data collection period and had an anticoagulant, diuretic, and opioid. R2’s Discharge Medication Orders dated 3/31/26, included ergocalciferol 1.25 milligrams (mg) (50000 unit) capsule by mouth once every week for 12 doses for vitamin D deficiency. R2’s medication administration record (MAR) April 2026, included ergocalciferol oral capsule was given 4/7/26 and 4/14/26, and the medication was not available on 4/21/26 and 4/28/26. R2’s Medication Record May 2026, included ergocalciferol oral capsule was not available on 5/5/26.	F0755		06/22/2026

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F0755 SS = D	Continued from page 20 In review of R1's record there was no indication of the pharmacy was notified of the missing medication, nor the physician notified the medication was not available for administration on 4/21/26, 4/28/26, and 5/5/26. During interview on 5/8/26 at 3:55 p.m., RN-B indicated if the medication was not available staff were supposed to call the pharmacy right away for medications which were not available to give, and the pharmacy would promptly deliver the medication During interview on 5/11/26 at 3:29 p.m., the interim director of nursing (DON) and RN-D, who was also a nurse manager, reviewed R1's medical documents. They verified R1 re-admitted to the facility on 3/23/26, and fidaxomicin should have been available for administration per the physician order. R2's record was reviewed and verified ergocalciferol was documented as not available. They expected nurses to write a progress note when medications were not available and document taken actions. RN-D expected the pharmacy and the physician be notified if there were issues with medication availability. DON stated there was a risk for extended infection when antibiotics were not given as ordered. Facility policy Medication Errors- R/S, LTC dated 3/2/26, identified omission of medication as a medication error. An omission was defined as the failure to administer an ordered dose to a resident by the time the next dose was due, assuming there was no prescribing error. No other medication related policies and procedures were received.	F0755		06/22/2026
F0880 SS = D	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:	F0880	F880 – Infection Prevention and Control DNS or designee reviewed resident R2s assessments to ensure no adverse effects from staff not following EBP, none noted. DNS or designee conducted a huddle at the time of review to reinforce EBP expectations. Resident R2 had a care plan completed to include EBP interventions 6/9. 2. All residents with catheters have the potential to be affected by the deficient practice. Specifically, all current residents on EBP precautions have had staff observation of their cares for adherence to the Facilities EBP policy on proper PPE usage during cares. 3. To ensure systemic changes are sustained, the	06/22/2026

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F0880 SS = D	Continued from page 21 §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 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.	F0880	Continued from page 21 CLDS RN has educated the nursing staff on the facility’s policy on EBP isolation and PPE usage. 4. To ensure compliance is sustained the Infection Preventionists/designee will audit 4 staff weekly performing cares for a resident who is on EBP isolation for adherence to the facility’s policy. Audit results will be brought to the monthly QAPI committee to assess the need to increase or decrease to ensure substantial compliance is achieved. 5. Compliance Date 6/22/26	06/22/2026

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F0880 SS = D	Continued from page 22 §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 enhanced barrier precautions (EBPs) and infection control measures were followed for 1 of 1 resident (R2) reviewed for urinary catheters. Findings include: Centers for Disease Control and Prevention defined EBP as the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multidrug-resistant organism; microorganisms, such as bacteria, which are resistant to one or more antimicrobial drugs) to staff hands and clothing. R2's admission Minimum Data Set (MDS) dated 4/6/26, indicated R2 had intact cognition and required setup or clean-up assistance with eating, personal hygiene, and oral hygiene and was dependent on staff for toileting hygiene, showering, dressing, bed and wheelchair mobility, and transfers. R2 had an indwelling catheter and diagnoses which included atrial fibrillation, heart failure, hypertension, benign prostatic hyperplasia (BPH), urinary tract infection, renal failure, arthritis, osteoporosis, and hip fracture. R2's care plan dated 4/15/26, indicated R2 had a catheter due to BPH and urinary retention. R2's physician Order Summary Report with order dated 3/31/26, directed staff to follow enhanced barrier precautions due to R2's foley catheter and incision. During an observation on 5/8/26, at 2:17 p.m. R2's signage by his door informed staff R2 required enhanced barrier precautions which directed staff to wear gloves and a gown for high-contact resident care activities. The sign indicated "Device care use: central line, urinary catheter, feeding tube, tracheostomy" were high-contact resident care activities. During interview on 5/8/26 at 2:17 p.m., nursing assistant (NA)-A stated they wore gloves but no	F0880		06/22/2026

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F0880 SS = D	Continued from page 23 gown to empty R2's catheter. NA-A reviewed the enhanced barrier precautions sign on R2's door and stated they only had to follow gowning and gloving guidance if the resident was in isolation, had a wound or infection, or when the nurses changed a catheter. During observation and interview on 5/8/26 at 4:18 p.m., NA-B wore gloves and no gown and emptied R2's urine from catheter bag in a clear, triangular container. NA-B wiped the emptying port with a paper towel and placed the port back into the protective holder. NA-B reviewed the sign on R2's door and stated they did not have to wear a gown to empty R2's catheter, but the nurses had to wear a gown and gloves when they changed R2's foot dressing. During interview on 5/8/26 at 2:52 p.m., NA-F stated they wore gloves but not a gown to empty catheter bags. During interview on 5/11/26 at 3:29 p.m., registered nurse (RN)-D, who was also the nurse manager, expected staff to wear a gown and gloves when emptying urine from a catheter bag and use an alcohol swab to clean the emptying port. RN-D stated EBP provided infection protection for staff and residents. During interview on 5/12/26 at 1:58 p.m., the interim director of nursing (DON) expected staff to wear a gown and gloves when emptying urine from a catheter bag. Facility policy Standard, Enhanced Barrier, and Transmission-Based Precautions, All Service Lines-Enterprise dated 4/30/26, directed staff to wear a gown and gloves to complete high-contact resident care activities, which included urinary catheter care. Facility policy Catheter: Care, Insertion, and Removal, Drainage Bags, Irrigation, Specimen- AL, R/S, and LTC dated 3/2/26, directed staff to clean drainage port with alcohol wipe and replace the drainage port in the holder after urine was emptied from catheter bag.	F0880		06/22/2026

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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 5/7/26, 5/8/26, 5/11/26, and 5/12/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were 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: H52211725C (2999256) with a licensing order issued	20000		06/22/2026

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

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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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20000	Continued from page 1 at 20830, 21390, and 21585. 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 14-01, available at 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	20000		06/22/2026
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	20830	Corrected	06/22/2026

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20830	Continued from page 2 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: Based on observation, interview, and document review, the facility failed to monitor and document urine output for 2 of 3 residents (R1 and R2) with indwelling urinary catheters. In addition, the facility failed to consistently assess, report, and document abnormal urine characteristics for 1 of 1 (R2) resident observed during catheter drainage bag emptying. The facility also failed to consistently document catheter care completion for 3 of 3 residents (R1, R2, and R3) with indwelling urinary catheters and failed to store a urinary catheter bag in a manner to reduce risk of infection for 1 of 1 resident (R3) who utilized a leg drainage bag during the day and a larger drainage bag overnight. Findings include: R1's admission Minimum Data Set (MDS) dated 2/5/26, indicated R1 had intact cognition, no mood or behavior concerns, or rejection of care. R1 required setup or clean-up assistance with eating, oral hygiene, personal hygiene; substantial/maximal assistance for upper body dressing, lower body dressing, putting on/taking off footwear, rolling left and right, sit to lying/lying to sitting on bed side, sitting to standing, chair/bed-to-chair transfers; and dependent on staff for toileting hygiene, showering, toilet transfers. R1 had an indwelling catheter and was frequently incontinent of bowel. R1's diagnoses included hypertension, benign prostatic hyperplasia (BPH), renal failure, diabetes mellitus, malnutrition, and glaucoma. R1's hospital Discharge Summary, with admission date of 3/18/26 and discharge date of 3/23/26, indicated R1 was hospitalized for clostridium difficile colitis and catheter-associated urinary tract infection. The urine culture grew E.coli. R1's care plan 4/29/26, indicated R1 had an indwelling catheter due to BPH, a urinary tract infection, and renal insufficiency due to chronic kidney disease. Staff were directed to: -Monitor/document pain/discomfort due to catheter. -Monitor for signs/symptoms (s/s) of discomfort on urination and frequency.	20830		06/22/2026

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20830	Continued from page 3 -Monitor/record/report to health care provider for s/s urinary tract infection (UTI): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. -May wear leg bag during the day and straight catheter drainage bag at night. -Report unusual observations/conditions to nurse. -Observe and report to nurse s/s of UTI frequency, urgency, foul smelling urine, pain with urination, fever, nausea, vomiting, back pain, lower abdominal pain, blood in urine, cloudy urine, altered mental status, change in level of consciousness, loss of appetite, behavior changes. -Encourage fluid intake. -Assist, supervise, remind R1 to wash hands after toileting and before and after meals. -Monitor/document/report for signs/symptoms of acute renal failure which included urine output. R1's progress notes reviewed between 3/1/26 to 4/26/26, indicated catheter care was provided once on 4/22/26. In review of R1's record there was no indication catheter care had been routinely completed on other days between the review dates of 3/1/26 through 4/26/26. In review of R1's urinary output documented between 4/15/26 to 4/25/26, the record identified inconsistent monitoring to ensure the catheter was patent or free from complications nor did the record include assessments/evaluation of accumulative daily totals of urinary output. The following was documented: -On 4/15/26, the record for urine output at 6:43 a.m. and 1:11 p.m. noted "response not required" and at 9:59 p.m. urine out was 550 cubic centimeters (cc; metric unit of volume) indicating a daily total of 550 cc's. -On 4/16/26, the record for urine output at 6:33 a.m. was 1,000 cc, 10:51 a.m. was 550 cc, and 9:32 p.m. was 800 cc indicating a daily total of 2,350 cc's. -On 4/17/26, the record for urine output at 6:34	20830		06/22/2026

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20830	Continued from page 4 a.m. was 1,000cc, “response not required” at 2:59 p.m., and 300 cc at 10:59 p.m. indicating a daily total of 1,300 cc’s. -On 4/18/26, the record for urine output at 6:51 a.m. was 600 cc’s. No other urine output was documented for 4/18/26. -On 4/19/26, the record for urine output at 6:41 a.m. was 2,000 cc and 575 cc at 10:59 p.m. indicating a daily total of 2,575 cc’s. -On 4/20/26, the record for urine output at 6:16 a.m. was 700 cc and 2:09 p.m. noted “response not required” indicating a daily total of 700 cc’s. -On 4/21/26, the record for urine output at 9:54 p.m. was 850 cc’s. No other urine output was documented for 4/21/26. -On 4/22/26, the record for urine output at 9:55 a.m. was 550 cc and 400 cc at 9:22 p.m. indicating a daily total of 950 cc’s. -On 4/23/26, the record for urine output at 6:33 a.m. noted “response not required” and 500 cc at 6:12 p.m. indicating a daily total of 500 cc’s. -On 4/24/26, the record for urine output at 6:10 a.m. was 850 cc and 550 cc at 10:59 p.m. indicating a daily total of 1,400 cc’s. -On 4/25/26, the record for urine output at 6:13 a.m. was 400 cc, and no other urine output was documented. R1’s physician visit dated 4/24/26 with a faxed time stamp of 4:10 p.m. identified R1 was seen for constipation and ongoing nausea and vomiting. Unable to keep solid food down, tolerates only light breakfast and liquid meals. An abdominal x-ray had been completed with negative for obstruction/constipation. The visit note did not address or mention urinary assessment or catheter related complications other than the mention of historic hospitalization from 3/18/26-3/23/26. R1’s progress note dated 4/24/26 at 9:05 p.m. Resident seemed upset and when asked what the problem was. He complained about his foley catheter not changed yesterday. He worries about a bladder infection and hospitalization. R1’s progress note dated 4/24/26 at 9:10 p.m. identified R1’s vital signs and blood sugar were within normal limit. Am shift reported he had	20830		06/22/2026

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20830	Continued from page 5 repeated emesis during the shift. No emesis was reported this shift at this time and his appetite was good. R1's progress note dated 4/24/26 at 9:15 p.m. indicated catheter was patent with clear yellow urine with no urinary complaints. R1's progress note dated 4/24/26 at 10:04 p.m. indicated urinary collection bag was not available. Foley was irrigated but resident wanted it changed. R1's record did not identify why the catheter was irrigated, if the irrigation was successful, and if R1 had discomfort as a result of the procedure. R1's progress note dated 4/25/26 at 4:38 a.m. included Resident requested to go to ER this afternoon due to severe abdominal pain after other inventions failed (interventions were not identified). Bladder residual scanned at this time was 26 ml, foley cath draining ok, urine was clear and free of sediments. Late entry progress note dated 4/26/26 at 1:11 p.m. indicated on Sunday 4/26/26 (inaccurate date as evidenced by hospital records) patients foley catheter was changed per his and resident representative request. He was complaining of bladder spasm and stated that the catheter wasn't working right, he was also bypassing urine. Patient reported the catheter was replaced by the overnight nurse. Patient then called his resident representative, and they brought in one from home and demanded that the catheter be changed right away. R1's Hospital Discharge Summary, with admission on 4/25/26 and discharge on 4/30/26, indicated R1 had abdominal pain and urine appeared "grossly infected". R1's diagnosis was acute pyelonephritis (bacterial infection causing inflammation of the kidneys) associated with bilateral hydronephrosis (both kidneys swollen due to urine backup). During interview on 5/7/26 at 2:10 p.m., NA-C stated they worked with R1, and R1 had complained he could not urinate before he was sent to the hospital on 4/25/26. NA-C stated they observed R1's catheter draining without concern and reported to nursing. NA-C stated nursing assistants documented residents' urinary output and nurses monitored if residents had more or less urinary output. During interview on 5/7/26 at 4:21 p.m., registered nurse (RN)-C stated they sent R1 into the hospital on 4/25/26 for abdominal pain. RN-C stated R1's	20830		06/22/2026

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20830	Continued from page 6 catheter was changed the previous shift, and R1 had clear urine in his catheter bag. During interview on 5/11/26 at 3:29 p.m. with the interim director of nursing (DON) and RN-D, who was also the nurse manager, continence and urinary charting were reviewed. The DON stated nurse managers reviewed nursing assistant charting to ensure accuracy. RN-D stated nurses on the floor reviewed urinary outputs from catheters at the end of each shift. RN-D stated they could not articulate if there were changes in urinary output, since there were shifts in which no urinary output was documented. Staff were directed to view the care plan for direction to complete catheter care and documented if prompted to in the “tasks”. R1’s care plan and nursing assistant tasks did not direct staff to perform or document catheter cares. R2 R2’s admission MDS dated 4/6/26, indicated R2 had intact cognition and required setup or clean-up assistance with eating and personal and oral hygiene and was dependent on staff for toileting hygiene, showering, dressing, bed and wheelchair mobility, and transfers. R2 had an indwelling catheter and was frequently incontinent of bowel. R2 had diagnoses which included atrial fibrillation, heart failure, hypertension, benign prostatic hyperplasia, urinary tract infection, renal failure, arthritis, osteoporosis, and hip fracture. R2 was at risk for pressure ulcers and had a surgical wound. R2’s care plan dated 4/15/26, indicated R2 had a catheter related to BPH and urinary retention. The care plan directed the staff to: -Monitor/document for pain/discomfort due to catheter. -Monitor for signs/symptoms of discomfort on urination and frequency. -Monitor/record/report to health care provider for s/s UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. -May wear leg bag during the day and straight catheter drainage bag at night. -Report unusual observations/conditions to nurse.	20830		06/22/2026

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20830	Continued from page 7 R2's Medication, Nursing, and Treatment Records from March to May 2026, directed staff to complete the following: -Change drainage bag every Friday and as needed if plugged and unable to clear with irrigation. -Change 16 French with 10 cc (cubic centimeter) balloon as needed if dislodged or plugged and unable to clear with irrigation. R2's progress notes dated 3/31/26 to 5/11/26, indicated catheter care was provided once on 4/3/26. R2's Follow Up Question Report for 5/1/26 to 5/11/26, the record identified inconsistent monitoring to ensure the catheter was patent or free from complications nor did the record include assessments/evaluation of accumulative daily totals of urinary output. The following was documented: -On 5/1/26, the record for urine output at 6:39 a.m. was 700 cc, at 11:13 a.m. noted "response not required", and 450 cc at 9:56 p.m. indicating a daily total of 1,150 cc's. -On 5/2/26, the record for urine output at 6:05 a.m. was 700 cc for a daily total of 700 cc's. -On 5/3/26, the record for urine output 700 at 6:38 a.m. was 700 cc and at 10:18 p.m. was 400 cc indicating a daily total of 1,100 cc's -On 5/4/26, the record for urine output at 6:21 a.m. was 700 cc, at 1:52 p.m. noted "response not required", and 700 cc at 9:58 p.m. indicating a daily total of 1,400 cc's. -On 5/5/26, the record for urine output at 5:02 a.m. noted "response not required", 650 cc at 10:33 a.m., and 300 cc at 9:25 p.m. indicating a daily total of 950 cc's. -On 5/6/26, the record for urine output at 1:36 p.m. was 450 cc and at 10:35 p.m. was 450 cc indicating a daily total of 900 cc's. During observation and interview on 5/7/26 at 2:10 p.m., NA-C wore gloves and gown to empty R2's catheter bag. The urine had a foul smell and a darkish yellow orange color. NA-C was about to dump the urine in the toilet when surveyor asked about the urine appearance. NA-C stated the urine	20830		06/22/2026

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20830	Continued from page 8 was a “deep yellow”, did not articulate further, and dumped urine into toilet. NA-C washed R2’s catheter tube and penial area with a soapy washcloth in the morning. Nursing assistants documented residents’ urinary output and nurses monitored if residents had more or less urinary output. During interview on 5/7/26 at 4:21 p.m., RN-C stated staff did not report any current urinary concerns to her for any resident during her shift, which included R2. RN-C stated it was important for staff to tell nursing about urinary concerns, so nursing could assess dehydration or urinary tract infections and have testing like a urinalysis and/or culture ordered. Review of R2’s record on 5/7/26 did include documentation of the noted darkish yellow/orange urine and foul odor nor a corresponding comprehensive assessment. Further no notation of catheter cares provided. R2’s urine output record did not include urine output for the day shift; On 5/7/26, the record for urine output at 10:22 a.m. was 650 cc and at 10:28 p.m. was 350 cc for indicating daily total of 1,000 cc’s. During interview on 5/8/26 at 2:17 p.m., NA-A stated they worked with R2. NA-A stated they did not have concerns with R2’s urine output and would chart R2’s output. NA’s would alert nurses If residents with a urinary catheter had no output, blood in the urine, fever, confusion, or anything unusual. During observation and interview on 5/8/26 at 4:18 p.m., NA-B stated they had not emptied R2’s catheter since the evening shift started and was not sure how much was emptied from the day shift. NA-B stated they had not heard of any concerns with R2’s urine. NA-B stated they washed R2’s penial area and catheter tubing with soap and water in the morning and evening. NA-B documented urinary output each time the catheter was emptied and would report to a nurse if urine was red, pink, thick, or had a strong smell. NA-B entered R2’s room and emptied R2’s urine from catheter bag in a clear graduated container. R2’s urine had a yellowish hue, tannish white particles, and a longer thick substance in the tubing as urine was emptied. NA-B stated they would report the urine appearance to the nurse and dumped the urine into the toilet. Review of R2’s record on 5/8/26 did not include documentation of R2’s urine integrity (yellowish hue,	20830		06/22/2026

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20830	Continued from page 9 tannish white particles, and a longer thick substance) nor evident corresponding comprehensive assessment was completed. R2's progress note dated 5/8/26 included "urinary catheter intact". R2's urine output was documented as at 6:51 a.m. noted "response not required" and at 10:38 p.m. was 550 cc indicating a daily total of 550 cc's. No urine output was recorded for the day shift. Further no notation of catheter cares were completed and provided. R2's urine output on 5/9/26 was left blank indicating R2 did not have any urine output. R2's progress note dated 5/9/26 indicated R2's urinary catheter was "changed" per "as needed for urinary retention" order. The note did not include urine characteristics. R2's urine output on 5/10/26 identified urine output at 6:15 a.m. was 450 cc, at 2:17 p.m. was 200 cc, and at 10:59 p.m. noted "response not required" for a daily total of 650 cc. R2's progress notes dated 5/10/26 indicated R2's urinary catheter change was noted as "effective", and Skilled Evaluation note indicated "urinary catheter intact." The notes did not include urine characteristics R2's urine output on 5/11/26, at 6:23 a.m. was 800 cc, 550 cc at 12:50 p.m., and 700 cc at 10:59 p.m. indicating a daily total of 2,050 cc's. During interview on 5/12/26 at 10:29 a.m., RN-A stated R2's urine usually looked yellow. RN-A stated nursing assistants should report if urine looked "deep yellow", foul smelling, or had particles and had not heard of any recent concerns with R2's urine. During interview on 5/8/26 at 2:52 p.m., NA-F stated they checked catheter bags for emptying needs at the beginning of their shift because sometimes the catheter bags were full, and NA-F was unsure if the morning shift emptied or not. NA-F would round on residents with urinary catheters throughout their shift and emptied when the catheter bags were full. NA-F stated they wrote down the urine amount emptied on their paper and documented the total urine output amount at the end of the shift. During interview on 5/8/26 at 3:17 p.m., RN-A stated signs and/or symptoms of urinary tract infection (UTI) included irritating, fever, burning and everyone had different UTI symptoms. RN-A stated they would assess urine, push fluids, ask providers for a urinary analysis and/or urinal culture, and	20830		06/22/2026

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20830	Continued from page 10 document if they noticed signs and/or symptoms of a UTI. RN-A stated nursing assistants charted urinary output for residents with a catheter and let the nurses know of urinary concerns, such as lack of output. RN-A stated they observed urinary conditions throughout their shift. During interview on 5/8/26 at 3:55 p.m., RN-B stated signs and/or symptoms of UTI included confusion, pain, cloudy or red urine. RN-B stated they would assess the catheter site and ensure catheter patency if they suspected any catheter related infection. RN-B stated staff documented urine and catheter concerns in progress notes. During interview on 5/11/26 at 3:29 p.m. with the interim director of nursing (DON) and RN-D, who was also the nurse manager, continence and urinary charting were reviewed. The DON stated nurse managers reviewed nursing assistant charting to ensure accuracy. RN-D stated nurses on the floor reviewed urinary outputs from catheters at the end of each shift. RN-D stated they could not articulate if there were changes in urinary output related to the shifts in which no urinary output was documented. The nursing assistants were expected to report to nursing about urinary concerns or lack of output. Nurses were expected to chart urinary concerns and monitor in a skilled note, progress note, or other clinical monitoring assessment. RN-D reviewed R2’s notes and indicated the notes did not note any “outside findings” besides the catheter change. Staff were directed to view the care plan for direction to complete catheter care and documented if prompted to in the “tasks”. R2’s care plan did not direct staff to complete or document catheter cares. R3 R3’s admission MDS dated 2/1/26, indicated R3 had moderate cognitive impairment and an indwelling catheter. R3 was dependent on staff with most activities of daily living and had diagnoses which included coronary artery disease, heart failure, neurogenic bladder, multiple sclerosis, and malnutrition. R3’s indwelling catheter care plan dated 1/28/26, directed staff to: -Monitor/document for pain/discomfort due to catheter. -Monitor for signs/symptoms of discomfort on urination and frequency.	20830		06/22/2026

Minnesota Department of Health

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20830	Continued from page 11 -Monitor/record/report to health care provider for s/s UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. -May wear leg bag during the day and straight catheter drainage bag at night. -Report unusual observations/conditions to nurse. R3's care plan did not direct staff to complete or document catheter cares. R3's Medication, Nursing, and Treatment Records from March to May 2026, directed staff to complete the following: -Change drainage bag every Friday and as needed if plugged and unable to clear with irrigation. -Change foley catheter every 30 days. -Change 22 French with 5 cc (cubic centimeter) balloon as needed if dislodged or plugged and unable to clear with irrigation. R3's progress notes dated 3/1/26 to 5/10/26 did not indicate catheter cares were completed except on 4/27/26 and 5/1/26. During observation and interview on 5/7/26 at 12:54 p.m., a catheter bag was between two towels on a dry shower chair. NA-E placed gloves on and observed the catheter. NA-E lifted the drainage bag to observe, and the top of the catheter bag tubing, the connector port, touched the shower curtain railing. The connector port did not have a cap on it, and the catheter bag had a noticeable amount of clear yellow urine. During a follow-up interview on 5/12/26 at 11:09 a.m., NA-E stated they cleaned the outside of the overnight catheter bag with an alcohol wipe or soapy towel before storing for later use. NA-E was unsure how to rinse out the inside of the overnight catheter bag. During observation and interview on 5/12/26 at 10:56 a.m., NA-D verified there was no cap on the connector port of R3's catheter bag which was stored between two towels on a dry shower chair. NA-D verified the presence of clear yellow urine in	20830		06/22/2026

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20830	Continued from page 12 the stored, overnight catheter bag. During interview on 5/12/26 at 10:29 a.m., RN-A stated they used to cap the connector ports of catheters bags stored during the day for later use and used to rinse out catheter bags with vinegar and water and was unsure about current cap use and rinsing practices for catheter bags. During interview on 5/11/26 at 3:29 p.m. with the interim director of nursing (DON) and RN-D, who was also the nurse manager, continence and urinary charting were reviewed. Staff were directed to view the care plan for direction to complete catheter care and documented if prompted to in the “tasks”. R3’s care plan and nursing assistant tasks did not direct staff to perform or document catheter cares. RN-D stated facility competency directed the staff to rinse a catheter bag. The DON and RN-D could not articulate a facility practice to cap the connector port tubing on catheter bags which were to be stored during the day or overnight for exchanges from leg to overnight/overnight to leg catheter bags. Facility policy Catheter: Care, Insertion, and Removal, Drainage Bags, Irrigation, Specimen- AL, R/S, and LTC dated 3/2/26, directed staff to complete catheter care in the morning and bedtime and as needed. Catheter care included: -inspect urine collection for color, clarity, and quantity. -observe urethral meatus and surrounding tissue for inflammation, encrustations, swelling, or discharge, and ask the resident if burning or discomfort is present. -provide perineal care with soap and water, peri-wash as directed or disposable wipes. -secure the catheter with the catheter securement device and secure the drainage bag and tubing below the level of the bladder. The policy directed staff to clean leg bags and straight drainage bag with warm soapy water or one part white vinegar and three parts water solution or an appropriate commercial solution by pouring solution into the bag, soak the bag for 30 minutes, drain the solution from the bag, rinse with warm water, hang to dry covered with a clean towel, and cover/cap the tubing once the bag is dry. The policy directed staff to store tubing caps in designated bag or container when not in use and clean with alcohol pad before recapping tubing. The policy directed	20830		06/22/2026

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20830	Continued from page 13 staff to record urine volume where appropriate. The policy directed staff to note amount and character of urine and report any signification observations to licensed nurse (blood, mucus, low urine output). SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, should review policies and procedures regarding proper catheter care and tubing management. The DON or designee should conduct routine audits for all residents with catheters to ensure proper care and management of catheter tubing. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		06/22/2026
21390	Infection Control CFR(s): MN Rule 4658.0800 Subp. 4 A-I Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants,	21390	Corrected	06/22/2026

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21390	Continued from page 14 antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBPs) and infection control measures were followed for 1 of 1 resident (R2) reviewed for urinary catheters. Centers for Disease Control and Prevention defined EBP as the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multidrug-resistant organism; microorganisms, such as bacteria, which are resistant to one or more antimicrobial drugs) to staff hands and clothing. R2’s admission Minimum Data Set (MDS) dated 4/6/26, indicated R2 had intact cognition and required setup or clean-up assistance with eating, personal hygiene, and oral hygiene and was dependent on staff for toileting hygiene, showering, dressing, bed and wheelchair mobility, and transfers. R2 had an indwelling catheter and diagnoses which included atrial fibrillation, heart failure, hypertension, benign prostatic hyperplasia (BPH), urinary tract infection, renal failure, arthritis, osteoporosis, and hip fracture. R2’s care plan dated 4/15/26, indicated R2 had a catheter due to BPH and urinary retention. R2’s physician Order Summary Report with order dated 3/31/26, directed staff to follow enhanced barrier precautions due to R2’s foley catheter and incision. During an observation on 5/8/26, at 2:17 p.m. R2’s signage by his door informed staff R2 required enhanced barrier precautions which directed staff to wear gloves and a gown for high-contact resident care activities. The sign indicated “Device care use: central line, urinary catheter, feeding tube, tracheostomy” were high-contact resident care activities. During interview on 5/8/26 at 2:17 p.m., nursing assistant (NA)-A stated they wore gloves but no gown to empty R2’s catheter. NA-A reviewed the enhanced barrier precautions sign on R2’s door and stated they only had to follow gowning and gloving	21390		06/22/2026

Minnesota Department of Health

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21390	Continued from page 15 guidance if the resident was in isolation, had a wound or infection, or when the nurses changed a catheter. During observation and interview on 5/8/26 at 4:18 p.m., NA-B wore gloves and no gown and emptied R2's urine from catheter bag in a clear, triangular container. NA-B wiped the emptying port with a paper towel and placed the port back into the protective holder. NA-B reviewed the sign on R2's door and stated they did not have to wear a gown to empty R2's catheter, but the nurses had to wear a gown and gloves when they changed R2's foot dressing. During interview on 5/8/26 at 2:52 p.m., NA-F stated they wore gloves but not a gown to empty catheter bags. During interview on 5/11/26 at 3:29 p.m., registered nurse (RN)-D, who was also the nurse manager, expected staff to wear a gown and gloves when emptying urine from a catheter bag and use an alcohol swab to clean the emptying port. RN-D stated EBP provided infection protection for staff and residents. During interview on 5/12/26 at 1:58 p.m., the interim director of nursing (DON) expected staff to wear a gown and gloves when emptying urine from a catheter bag. Facility policy Standard, Enhanced Barrier, and Transmission-Based Precautions, All Service Lines-Enterprise dated 4/30/26, directed staff to wear a gown and gloves to complete high-contact resident care activities, which included urinary catheter care. Facility policy Catheter: Care, Insertion, and Removal, Drainage Bags, Irrigation, Specimen- AL, R/S, and LTC dated 3/2/26, directed staff to clean drainage port with alcohol wipe and replace the drainage port in the holder after urine was emptied from catheter bag. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policies/procedures regarding isolation and or/enhanced barrier precautions for the resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They could also do environmental rounds, audits, and re-education anytime isolation precautions are placed. The ICP should have formal training to be	21390		06/22/2026

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21390	Continued from page 16 completed according to regulation and head the above measures. The ICP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		06/22/2026
21585	Administration of Medications; documentation CFR(s): MN Rule 4658.1325 Subp. 8 Subp. 8. Documentation of administration. The name, date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized person who administered and observed the same must be recorded in the resident's clinical record. Documentation of the administration must take place following the administration of the medication. If administration of the medication was not completed as prescribed, the documentation must include the reason the administration was not completed, and the follow-up that was provided, such as notification of a registered nurse or the resident's attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure medications were available for administration per physician order for 2 of 3 residents (R1 and R2) reviewed for medication errors. Findings include Findings include R1’s admission Minimum Data Set (MDS) dated 2/5/26, indicated R1 had intact cognition, no mood or behavior concerns, or rejection of care. R1 required setup or clean-up assistance with eating, oral hygiene, personal hygiene; substantial/maximal assistance for upper body dressing, lower body dressing, putting on/taking off footwear, rolling left and right, sit to lying/lying to sitting on bed side, sitting to standing, chair/bed-to-chair transfers; and dependent on staff for toileting hygiene, showering, toilet transfers. R1 had an indwelling catheter and was frequently incontinent of bowel. R1’s diagnoses included hypertension, benign	21585	Corrected	06/22/2026

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21585	Continued from page 17 prostatic hyperplasia (BPH), renal failure, diabetes mellitus, malnutrition, and glaucoma. R1's Discharge Summary dated 3/23/26, indicated R1 admitted to the hospital 3/18/26 for clostridium difficile colitis and catheter-associated urinary tract infection. Discharge medications included fidaxomicin (an antibiotic used to treat diarrhea and kill bacteria or prevent bacterial growth) 200 mg (milligrams) by mouth twice daily for seven days for clostridium difficile bacteria. R1's hospital Medication Administration Record (MAR) dated 3/23/26 identified R1 was administered fidaxomicin at 8:00 a.m. indicating an evening dose was required. R1's admission physician orders included the order for fidaxomicin twice daily however, identified the start date for administration was on 3/24/26 and not 3/23/26. R1's medication administration record (MAR) included the physician order for fidaxomicin and identified a start date of 3/24/26 at 8:30 a.m. The MAR identified R1did not receive the 3/23/26 evening dose. Additionally, the MAR identified the 8:30 a.m. dose was not administered and marked as "drug not available". The MAR identified the remaining doses were administered as scheduled. R1's progress notes 3/23/26 to 3/31/26, identified R1 returned to the facility on 3/23/26 and started antibiotic. In review of R1's record there was no indication the physician was notified R1 missed two doses of the antibiotic and did not identify actions that were taken for the unavailable medication. R2 R2's admission MDS dated 4/6/26, indicated R2 had intact cognition and required setup or clean-up assistance with eating and personal and oral hygiene and was dependent on staff for toileting hygiene, showering, dressing, bed and wheelchair mobility, and transfers. R2 had an indwelling catheter and was frequently incontinent of bowel. R2 had diagnoses which included atrial fibrillation, heart failure, hypertension, benign prostatic hyperplasia, urinary tract infection, renal failure, arthritis, osteoporosis, and hip fracture. R2 was at risk for pressure ulcers and had a surgical wound. R2 received one injection during the seven days of the MDS data collection period and had an anticoagulant, diuretic, and opioid.	21585		06/22/2026

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21585	Continued from page 18 R2’s Discharge Medication Orders dated 3/31/26, included ergocalciferol 1.25 milligrams (mg) (50000 unit) capsule by mouth once every week for 12 doses for vitamin D deficiency. R2’s medication administration record (MAR) April 2026, included ergocalciferol oral capsule was given 4/7/26 and 4/14/26, and the medication was not available on 4/21/26 and 4/28/26. R2’s Medication Record May 2026, included ergocalciferol oral capsule was not available on 5/5/26. In review of R1’s record there was no indication of the pharmacy was notified of the missing medication, nor the physician notified the medication was not available for administration on 4/21/26, 4/28/26, and 5/5/26. During interview on 5/8/26 at 3:55 p.m., RN-B indicated if the medication was not available staff were supposed to call the pharmacy right away for medications which were not available to give, and the pharmacy would promptly deliver the medication During interview on 5/11/26 at 3:29 p.m., the interim director of nursing (DON) and RN-D, who was also a nurse manager, reviewed R1’s medical documents. They verified R1 re-admitted to the facility on 3/23/26, and fidaxomicin should have been available for administration per the physician order. R2’s record was reviewed and verified ergocalciferol was documented as not available. They expected nurses to write a progress note when medications were not available and document taken actions. RN-D expected the pharmacy and the physician be notified if there were issues with medication availability. DON stated there was a risk for extended infection when antibiotics were not given as ordered. Facility policy Medication Errors- R/S, LTC dated 3/2/26, identified omission of medication as a medication error. An omission was defined as the failure to administer an ordered dose to a resident by the time the next dose was due, assuming there was no prescribing error. No other medication related policies and procedures were received. SUGGESTED METHOD OF CORRECTION: The administrator, DON, and consulting pharmacist could review and revise policies and procedures for appropriate medication administration, which may	21585		06/22/2026

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21585	Continued from page 19 include but is not limited to the need for verifying orders and accurately transcribing and appropriate notification to the physician if medication administration does not occur. Staff could be educated on the reviewed and/or revised policies and procedures. The DON or designee could audit medication administration and take those results to the Quality Assurance Performance Improvement (QAPI) committee for a set amount of time to determine compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21585		06/22/2026