STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Stillwater	1119 Owens Street North Stillwater, MN 55082

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and document review, the facility failed to employ either a full-time registered dietitian (RD) or a qualified dietary manager (DM) to carry out the functions of the food and nutrition service. This had the potential to affect all 34 residents who resided in the facility.Findings include:Dietary manager qualifications were requested however were not received. The registered dietitian worked part time at facility. When interviewed on 2/11/26 at 2:00 p.m., the administrator stated the facility had a part time dietitian who worked between two facilities. The administrator stated dietary manager did not have required qualifications however was signed up for classes. When interviewed on 2/12/26 at 1:08 p.m. stated DM had accepted the role in November as DM. DM verified she was not currently qualified however had re-enrolled in classes.

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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure weekly wound assessments and measurements were completed for 1 of 1 resident (R3) reviewed for pressure ulcers (PU).Findings include:R3's admission Minimum Data Set (MDS) dated [DATE], indicated R3 was cognitively intact, required partial to substantial assistance with most activities of daily living (ADLs), did not display rejection of care behaviors, and has one stage-four pressure ulcer. R3's diagnoses included fracture of left arm, open wound on left elbow, received intravenous (IV) medications and osteomyelitis (a bone infection). R3's care area assessment (CAA) dated 1/19/26, indicated, Pressure injury to left elbow related to fracture, impaired ROM [range of motion], Osteomyelitis/cellulitis [bone/skin infection] infection puts patient at risk of complications like sepsis, increased care needs, further functional or cognitive decline and disability. R3's care plan (CP) dated 1/13/26, indicated R3 had potential and actual skin impairment and an actual stage four pressure ulcer with osteomyelitis to the left elbow. The care plan instructed staff to, Monitor location, size and treatment of skin injury .Assess/record/monitor wound healing daily with daily dressing changes. R3's physician order dated 1/19/26, indicated, document wound measurements every Monday. R3's progress note (PN) dated 1/13/26, indicated, Deep pressure wound over left elbow olecranon [the bony prominence of the elbow], visible bone with purulent drainage. The PN had no indication of size of wound. R3's PN dated 1/16/26, indicated, Wound cares to left elbow. No further assessment of wound documented. R3's PN dated 1/20/26, indicated, wound cares.no signs of wound infection. No further assessment or measurement of wound documented. R3's PN dated 1/23/26, indicated, wound cares to left elbow. No further assessment or measurement of wound documented. R3's PN dated 1/27/26 at 3:32 p.m., indicated (R3) returned from orthopedics appointment and note from ortho indicated, Left elbow 3x3 cm open wound/draining bursitis. Diagnosis: Infected left olecranon bursitis left proximal humerus. A second PN at 11:42 p.m., indicated, wound care and dressing changes to left elbow. No further assessment of wound. R3's PN dated 2/6/26, indicated, wound care completed as ordered. No further assessment or measurement of wound documented. R3's wound data collection form dated 1/30/26, indicated left elbow wound with intact dressing, no drainage, pink and intact tissue surrounding dressing. No wound characteristics to include appearance or measurements documented. cleansed with wound cleanser. The form further indicated, Required for documenting daily monitoring of pressure ulcers. Required at least weekly when skin integrity is impaired or open area is present.Measurements-Required at least once every 7 days. Review of additional wound data collection forms indicated initial form completed on 1/16/26, and subsequent form dated 1/29/26, lacked evidence of any wound measurements. R3's wound RN assessment dated [DATE], indicated, Required at least every 7 days and PRN [as needed] when skin integrity is impaired or open area is present. The assessment indicated a wound present with full thickness tissue loss and interventions in place. The assessment lacked any further wound assessment or measurements. R3's January 2026, treatment administration record (TAR) indicated, document wound measurement every Monday, start date 1/26/26. Documented as completed on 1/26/26. Review of R3's electronic medical record (EMR) lacked evidence of any measurements documented on 1/26/26. R3's February 2026, TAR indicated, document wound measurement every Monday, start date 1/26/26. Documented as completed on 2/2/26 and 2/9/26. Review of R3's EMR lacked evidence of any measurements documented on 2/2/26. Or 2/9/26. During observation and interview on 2/10/26 at 1:32 p.m., licensed practical nurse (LPN)-A cleansed R3's wound and replaced the dressing that had fallen off. LPN-A stated she had already completed full wound care this morning but since the dressing had fallen off, she cleaned it again prior to replacing the dressing. LPN-A stated R3 admitted with the stage 4 pressure ulcer, and it had not changed since then; no better no worse. During observation on 2/11/26 at 7:34 a.m., registered nurse (RN)-A completed R3's wound care. Review of (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's EMR lacked evidence of any wound assessment or measurements documented on 2/10/26 or 2/11/26. During interview on 2/12/26 at 9:51 a.m., LPN-A stated wounds should be assessed with wound care and weekly with wound rounds. LPN-A stated the assessments should be completed by the nurse and documented in the EMR-either in a progress note or one of the wound forms. LPN-A stated the assessments should include a description and weekly wound measurements and findings should be documented in the EMR. LPN-A further stated an initial assessment with measurements should be obtained and documented in order to base any changes observed on the weekly assessments. During interview on 2/12/26 at 10:49 a.m., director of nursing (DON) stated expectations for wound assessments with wound description and measurements should be completed every seven days and findings documented, and an initial assessment of those findings should be completed within 24 hours of admission. DON stated she and the nurse practitioner round weekly and measure and take pictures of the wounds. DON was not sure where the pictures, assessments or measurements were routinely being documented, nor who was completing the documentation. DON stated there were currently three different forms for skin/wound assessment and realized the system was broken. During follow up interview on 2/12/26 at 12:48 p.m., DON stated weekly wound measurements were being collected from several sources throughout the EMR and transferred to a separate spreadsheet and sent to corporate every month. DON could not explain why there was not a more streamlined process for documenting the wound assessments and why they could not all be located in the EMR. DON stated again the system was broken. Facility policy Wound and Pressure Ulcer Management dated 7/7/25, indicated accurate assessment and documentation of wounds were used to promote healing, pain and prevention of complications of wounds and contribute to appropriate wound management.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a root cause analysis was completed and implement new interventions following a fall for 1 of 3 residents (R11).Findings include: R11's annual Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of dementia (decline in cognitive ability), abnormalities of gait and mobility, difficulty in walking, muscle weakness, and repeated falls. It further indicated R11 required partial to moderate assistance with ambulation and had two or more falls since admission, one with injury. R11's progress note dated 10/23/25, indicated R11 was found on the floor in middle of the dining room. Her wheelchair was 10 feet away from the table and the other chairs surrounding her were 5 feet away. R11 was assessed for injuries and lacerations were noted on her head. Neurological checks were initiated with no changes and vital signs were stable. The patient was assisted off the floor by two staff. Patient was able to bend her knees and assist. Ice was placed on her head to control the bleeding. Her daughter was called and requested that the patient be seen at the hospital. The provider and director of nursing (DON) were updated as well. The patient was sent to the hospital for evaluation and treatment. R11's care plan reviewed on 2/9/26, showed: -On 2/18/25, R11 required a gait belt, walker, and stand by assist with one staff contact guard for ambulation in room and to and from meal/activities. -R11 had an actual fall on 9/15/25, with intervention to establish toileting plan and review history of recurrent falls. -R11 had an actual fall on 9/15/25, had a fall and Interventions directed staff to provide activities to promote exercise and strength building when possible.However, R11's care plan did not indicate R11 fell on10/23/25 or show any new fall interventions had been implemented. R11's [NAME] Accountability for Excellence (SAFE) resident event report (undated), indicated R11 had an unwitnessed fall in the dining room on 10/23/25, with an immediate intervention to assist R11 to her room after meals. This intervention had already been initiated on 2/18/25. The SAFE report also lacked indication of a root cause analysis. R11's 10/23/25 fall's root cause analysis was requested however was not received. During interview on 2/11/26 at 10:12 a.m., licensed practical nurse (LPN)-A stated when a resident falls, nurses were responsible for documenting it in a SAFE event incident report which would then also trigger a variety of other reports such as the Fall Tools assessment, pain assessment, etc. LPN-A further stated nurses were expected to put in a new intervention with each fall and add it to the care plan. Then the MDS nurse was responsible for making sure the interventions were appropriate and ensuring they were added to the care plan. During interview on 2/11/26 at 1:24 p.m., registered nurse (RN)-B stated nurses were responsible for filling out a SAFE event report and a new intervention each time a resident fell. Then the Interdisciplinary Team (IDT) will assess the interventions to determine if they are appropriate and add or remove them as needed. RN-B verified R11 did not have any new interventions on her care plan or Kardex, following her fall on 10/23/25. Staff should be looking at the Kardex in order to know what specific care each resident needs. During interview on 2/12/26 at 11:54 a.m., the director of nursing (DON) stated when a resident falls, nurses were responsible for documenting it on the SAFE event report. They should be documenting a description of the incident, the assessment of the resident, and picking an intervention from the list and adding it to the care plan. The DON further stated she and RN-B were responsible for ensuring the interventions were appropriate and new stating you can't use the same one twice. They were also responsible for completing a root cause analysis in order to prevent the incident from happening again. The nurses should be looking at the care plan when determining what type of care each resident needs and the nursing assistants should utilize the Kardex. The surveyor asked for documentation of the root cause analysis for R11's fall on 10/23/25 and upon giving me the SAFE event report for that date, the DON stated she could only give me part of the report, because the rest of it was QAPI protected. The facility policy regarding fall prevention and management dated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/14/25, indicated in step 16 of the procedure for a resident who has fallen was to review and update the care plan with any changes/new interventions. Furthermore, the policy directed staff to complete the fall investigation in the notes tab of risk management.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to identify triggers or attempt to identify triggers to avoid potential re-traumatization and failed to develop a care plan to include individualized trauma-informed approaches for 1 of 1 resident (R1) who had a history of trauma.Findings include:R1's admit Minimum Data Set (MDS) assessment, dated [DATE], indicated R1 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R1 was independent for all activities of daily living (ADLs), with occasional incontinence. R1 ambulated around facility with a wheeled walker. R1's diagnoses included post-traumatic stress disorder (PTSD) and bipolar disorder (mood disorder).R1's trauma assessment dated [DATE], indicated the purpose of the assessment was to identify residents who are trauma survivors. R1's trauma assessment indicated R1 did not have past trauma. R1's care plan dated [DATE], indicated R1 had sleep disturbance related to PTSD. Staff directed to monitor for complaints of feeling tired, irritability, dozing during activities, dark circles under eyes, change ability to perform ADL's, change in walking/falls, change in energy level, or change in medication. Interventions included to observe and document sleep. Furthermore, the care plan lacked identification of any PTDS triggers or interventions. R1's nursing assistant Kardex was requested however was not received. During an interview on [DATE] at 3:50 p.m., R1 stated he had PTSD and had known triggers. R1 stated staff at the facility had never talked to him about his triggers or past trauma. R1 stated triggers, included loud noises or being unaware of people behind him. R1 stated he was willing to talk to staff about triggers. R1 discussed his PTSD, started from being in Vietnam war and then found his wife deceased . During an interview on [DATE] at 12:17 p.m., certified nursing assistant (CNA)-A stated if a resident had a history of PTSD and had triggers it would be important to know what their triggers were to better care for them. CNA-A stated their triggers would be on the care plan and Kardex if a resident had PTSD. During an interview on [DATE] at 2:15p.m., licensed practical nurse (LPN)-A stated they identify individual resident's needs would be on the care plan and the Kardex. The nurses and MDS put the information from the chart into the care plan.During an interview on [DATE] at 2:47 p.m., director of nursing (DON) stated if a resident had PTSD they needed to be assessed for triggers, and those triggers would be documented on the care plan to help better care for the residents. DON stated assessments for triggers were done upon admission, and as needed, and stated these assessments would help identify any triggers, and behaviors would also be monitored. DON stated that she was unaware the Trauma Assessment was answered incorrectly and that the R1 care plan did not have triggers or any information regarding the diagnosis of PTSD.A facility policy titled Trauma Informed Care dated [DATE], directed staff to ensure that residents who experienced trauma receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization. Each employee will have training in caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or posttraumatic stress disorder.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to identify prior appropriate interventions prior to use of grab bars, assess for risk of entrapment, and obtain consent 1 of 1 resident (R12) reviewed for the use of grab bars. Findings include: R12's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of muscular sclerosis (disease that causes breakdown of the protective covering of nerves) and chronic kidney disease (condition in which the kidneys gradually lose their ability to function properly). It further indicated bilateral impairment of the lower extremities ([NAME]) and R12 required substantial assistance with bed mobility.During interview and observation on 2/09/2026 at 3:05 p.m., R12 had bilateral grab bars on her bed. R12 stated she didn't use the bars and was able to reposition herself. She further indicated she thinks the facility uses them to keep us in bed.R12's physical device assessment dated [DATE], lacked indication the facility identified and used appropriate alternatives prior to use of grab bars, educated R12 on risks versus benefits of grab bars. assessed R12's risk for entrapment or obtained informed consent. R12's care plan dated 1/12/26, indicated R12 had an activity of daily living (ADL) self-care performance deficit related to multiple sclerosis as evidenced by deconditioning and weakness. It further included the following interventions:-Bed mobility: extensive assist of one staff with lower extremities. Can assist with turning and repositioning in bed with use of assist bars. Offer to lay down after naps. Resident is able to use her bilateral assist bars to help with turning and repositioning. -Bed mobility: sitting to lying- assist of two staff with total body lift and guided maneuvering of [NAME].-Resident can roll side to side with extensive assist of one staff using grab/assist bars and staff guiding lower extremities that does not restrict freedom of movement.During interview on 2/12/26 at 9:42 a.m., nursing assistant (NA)-C stated R12 used the grab bars to assist staff to reposition her. During interview on 2/12/26 at 9:54 a.m., licensed practical nurse (LPN)-B stated nurses were responsible for assessing residents for grab bars and it should be documented on the physical device assessment. During interview on 2/12/26 at 10:37 a.m., registered nurse (RN)-B stated nurses were responsible for assessing residents for grab bars and it should be documented in the physical device assessment. RN-B also verified R12's grab bars had not been assessed and should have been.During interview on 2/12/26 11:54 a.m., the director of nursing (DON) stated nurses were responsible for assessing the residents for grab bars to ensure they meet criteria for safe use. There also needs to be collaboration with the provider and consent for their use. Documentation of this would be on the physical device assessment. DON stated this was important to ensure resident safety. The facility's policy on bed safety dated 9/30/25, indicated prior to use of bed rails, side rails, safety rails, grab bars and assist bars a PhysicalDevice and Restraint Assessment or Matrix equivalent will be completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure staff used appropriate personal protective equipment (PPE) for 2 of 2 residents (R3, R27) observed for enhanced barrier precautions (EBP).Findings include:R3 R3's admission Minimum Data Set (MDS) dated [DATE], indicated R3 was cognitively intact, required partial to substantial assistance with most activities of daily living (ADLs), did not display rejection of care behaviors, and has one stage-four pressure ulcer. R3's diagnoses included fracture of left arm, open wound on left elbow, received intravenous (IV) medications and osteomyelitis (a bone infection). R3's care area assessment (CAA) dated 1/19/26, indicated, Pressure injury to left elbow related to fracture, impaired ROM [range of motion], Osteomyelitis/cellulitis [skin infection] infection puts patient at risk of complications like sepsis, increased care needs, further functional or cognitive decline and disability. R3's care plan dated 1/13/26, indicated R3 required IV medication via Single Lumen-Right Basilic [peripherally inserted central catheter-PICC]-placed 1/9 for Long Term antibiotics [ATB]. The care plan further indicated R3 required EBP due to open wound growing Staph Aureus (infection) and instructed staff to Don [put on] gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene.device care and/or use, and wound care. R3's provider order report printed 2/11/26, included the following: -wound soak with warm soapy water three times a day to left elbow three times a day -wound care to left elbow three times a week -change PCC line dressing and caps weekly -IV ATB until 2/20/26 During observation and interview on 2/11/26 at 7:34 a.m., registered nurse (RN)-A entered R3's room. RN-A did not don gloves or gown. R3 sitting in recliner. RN-A proceeded to fill a basin with warm soapy water and soaked R3's elbow in the water. After soaking, RA-A placed new dressing to cover wound. RN-A washed hands and then gathered supplies for the IV administration. RN-A flushed R3's PICC line and attached the IV ATB medicine ball (an enclosed self-infusing system). When asked, RN-A stated, I should be wearing gloves, but I'm old school. Upon exit from R3's room, RN-A confirmed EBP signs and PPE present on R3's door and stated she should have donned a gown and glove to perform the tasks she just completed. During interview on 2/12/26 at 10:21 a.m., director of nursing, who is also the infection preventionist (DON/IP) interview stated expectation that EBP should be followed when there is an indwelling device like an IV or PICC and when with open wounds. DON further stated when a resident was on EBP, gown and glove should always be worn during direct patient care. R27 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's quarterly Minimum Data Set (MDS) assessment dated [DATE], was moderate cognitively impairment with slow mentation, R27 had range of motion limitations to upper and lower extremities, and was dependent on staff for lower body care, bed mobility, and transfers. It also indicated R27 had a urinary catheter and hospice care on admission, history of traumatic brain injury, and acute kidney failure. R27's physician order dated 11/26/25, indicated R27 had an indwelling catheter for traumatic brain injury. Urinary catheter had a bag covered for dignity, and catheter care documented. Enhanced barrier protocol (EBP) to be implemented for cares of R27. R27's catheter care plan dated 11/26/25, indicated R27 had indwelling catheter related to traumatic brain injury. Interventions included documented intake/output, monitor, record and report to provider for signs and symptoms of urinary tract infection (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 or eating patterns). Catheter cares completed every shift. R27's EBP care plan updated on 2/10/26, for indwelling catheter, urine had multidrug resistant organisms (MRDO) that made infections hard to treat. Interventions were put on gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing, device care and/or use, and wound care. Take off gown and gloves inside resident room, then perform hand hygiene. During observation and interview on 2/10/26 at 11:06 a.m., Outside of R27's room had no signs or EBP supplies. Certified nursing assistant (CNA)-B entered R27's room without wearing a gown or gloves. CNA- B proceeded to complete R27's catheter cares were performed without EBP. CNA-B stated the care plan and Kardex gave information if a resident was on EBP. If there was not a yellow door holder on the resident's door or plastic bin in the hallway with EBP supplies or a sign on the door, a resident was not on EBP. CNA-B verified R27's door did not have a sign and no EBP supplies were outside of R27's room, therefore not on EBP. During interview on 2/11/26 at 7:24 a.m., licensed practical nurse (LPN)-A stated EBP was to be used when physical cares were provided to residents on EBP. The care plan interventions are listed for EBP, such as yellow holder and signage on door with EBP supplies in it, and the treatment administration record to document cares. The training was provided by facility, online, skill fairs, staff meetings and demonstrations. During interview on 2/12/26 at 12:30 p.m., CNA-A stated received education on catheter care online education provided by facility. The expectations for catheter care were to empty bag at end of shift, wear gloves, clean end with alcohol wipe, document intake and output, report changes to nurse. CNA-A further stated other PPE was not necessary for catheter cares. During interview on 2/12/26 at 2:25 p.m., the infection preventionist (IP)/ director of nursing (DON) stated the expectation of staff was to adhere to the policy for enhanced barrier precautions. Staff was to properly don and doff protective personal equipment, every single time when doing cares with a resident on EBP. R27 should have been on EBP since admission. The rationale was to decrease the risk of transmission, decrease infections, keep staff and residents healthy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Standard, Enhanced Barrier and Transmission Based Precautions dated 7/7/25, directed staff to use EBP in situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Enhanced barrier precautions are also used for residents with indwelling medical devices, central lines, hemodialysis catheters, and indwelling urinary catheters. High-contact resident care activities include transfers, dressing, assisting during bathing, providing hygiene, changing briefs or assisting with toileting, changing linens, indwelling urinary catheter, and wound care. Enhanced barrier precautions are intended to be used for the duration of a resident's stay.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Stillwater	1119 Owens Street North Stillwater, MN 55082

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and document review, the facility failed to ensure the daily staff posting displayed accurate data regarding the resident census, along with the total number and actual hours worked per shift by nursing staff. This had the potential to affect all 34 residents residing in the facility and their visitor who may wish to review the information.Findings include: Actual working staff schedules on daily assignment sheets for 2/1/26 - 2/11/26 indicated the following:2/1: 6 nurses, 8 CNAs2/2: 6 nurses, 7 CNAs2/3: 6 nurses, 8 CNAs2/4: 6 nurses, 9 CNAs2/5: 5 nurses, 10 CNAs2/6: 6 nurses, 8 CNAs2/7: 6 nurses, 7 CNAs2/8: 6 nurses, 10 CNAs2/9: 6 nurses, 9 CNAs2/10: 6 nurses, 8 CNAs2/11: 6 nurse, 8 CNAs Daily staff postings for 2/1/26 - 2/11/26 indicated the following:2/1: 6 nurses, 5 CNAs2/2: 6 nurses, 6 CNAs2/3: 6 nurses, 6 CNAs2/4: 6 nurses, 6 CNAs2/5: 5 nurses, 6 CNAs2/6: not provided2/7: not provided2/8: 5 nurses, 7 CNAs 2/9: 5 nurses, 5 CNAs2/10: 6 nurses, 6 CNAs2/11: 5 nurse, 6 CNAs During observation on 2/11/26 at 8:24 a.m., facility staff posting at the reception desk indicated a date of 2/11/26, with a census of 35. Census in the electronic health record (EHR) indicated current census of 34. The staff posting further indicated 6 certified nursing assistants for the day. The daily staff schedule for 2/11/26 indicated 8 CNAs for the day. In addition, the daily staff postings for 2/12/26 through 2/15/26 were already posted behind the current daily posting in a plastic display frame all indicating a census of 35 and pre-populated staff numbers and hours. During interview on 2/11/26 at 10:50 a.m., scheduler stated the process was to print the daily postings about a week in advance and place them in the display stand at the front desk. Then someone from the night staff would remove the top sheet every day and place it in the mailbox for retention. Scheduler stated the daily posting was not updated daily to reflect the actual census or the actual staff working each day. During interview on 2/12/26 at 10:44 a.m., director of nursing (DON) stated the scheduler printed the staff posting the day prior and then it was posted in the morning. DON stated the scheduler should be updating the information to reflect the actual census and daily staff numbers and hours so that the posted sheet displayed accurate data. During observation on 2/12/26 at 12:08 p.m., the daily staff posting was dated 2/11/26. During interview on 2/12/26 at 12:11 p.m., administrator verified current staff posting displayed was dated 2/11/26. Administrator further stated expectation that the daily staff posting would be current and accurate and reflect the current resident census and direct care staff numbers and hours. Facility policy Nursing Staff Daily Posting Requirements dated 12/1/25, indicated a daily staff posting would include the location, date, resident census, and total number and actual hours worked for licensed and unlicensed nursing staff. The policy further indicated, It is important to keep the report updated by making changes as thy occur to the electronic schedule.and a new report will need to be printed and posted.