STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Maplewood	550 Roselawn Avenue East Saint Paul, MN 55117

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a comprehensive care plan for two out of four residents (R5, R7) when the care plan did not include dialysis services, goals/outcomes, and interventions. Findings include:R5's provider order dated 1/23/26 indicated R5 was to receive dialysis at an outside dialysis center on Mondays, Wednesdays, and Fridays. R5's dialysis treatment was to start at 2:15 p.m. R5 would use a transportation company to bring him from the facility to the outside dialysis center. R5's care plan dated 1/23/26 did not include dialysis services, goals/outcomes, and interventions. R5's MDS dated [DATE] indicated R5 was admitted to the facility with a primary diagnosis of fractures and other multiple traumas. R5's additional diagnosis included dependence on renal dialysis. The MDS indicated R5 was on dialysis. R5's progress notes did not indicate what type of dialysis access he had. R7's provider order dated 2/9/26 indicated R7 was to receive dialysis at an outside dialysis center on Mondays, Wednesday's, and Fridays. R7 was to use an outside transportation company to bring him from the facility to the outside dialysis center. R7's care plan dated 2/10/26 did not include dialysis services, goals/outcomes, and interventions. R7's MDS dated [DATE] indicated R7 was admitted to the facility with a primary diagnosis of medically complex conditions. R7's additional diagnoses included chronic kidney disease stage 3B and dependence on renal dialysis. R7's progress notes did not indicate what type of dialysis access he had. During an interview on 3/23/26 at 9:44 a.m., registered nurse (RN)-A stated she did not recall what type of dialysis R5 received or how he got to the outside dialysis center but would check his care plan to find out. During an interview on 3/24/26 at 10:17 a.m., RN-D stated she did not recall what type of dialysis R7 received or how he got to the outside dialysis center but would check his care plan to find out. During an interview on 3/24/25 at 12:07 p.m., RN-E stated if any facility staff had questions about where a resident received dialysis treatment, how the resident got to and from the outside dialysis center, and what type of dialysis access a resident has, the staff member would look in the resident's care plan. RN-E stated the purpose of a resident's care plan is to let the staff member know the resident was on dialysis and where the resident goes for dialysis. RN-E stated RN-F and RN-G were responsible for creating a resident's care plan. During an interview on 3/24/26 at 12:51 p.m., RN-F stated she was the primary staff member that would make a resident's care plan. RN-F stated when a resident is admitted , the primary nurse working with that resident would make the initial care plan and then RN-F would go back to the resident's care plan, make revisions to the care plan, and then finalize it. RN-F stated the outside dialysis center information, when the resident receives dialysis, and transportation to and from the dialysis center should be on a resident's care plan if the resident is receiving dialysis. During an interview on 3/24/26 at 1:05 p.m., RN-G stated all staff from the interdisciplinary team (IDT) can make changes and finalize a resident's care plan. RN-G stated the outside dialysis center information, when the resident receives dialysis, and transportation to and from the dialysis center should be on a resident's care plan if the resident is receiving dialysis. The policy Care Plan dated 12/1/25 indicated a resident's care plan would emphasize the care and development of the whole person ensuring that the resident would receive appropriate care and (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	services. The care plan would address the relationship of items or services required and facility responsibility for providing those services.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who required dialysis receive such services that were consistent with professional standards of practice for three out of five (R1, R5, R7) residents when the facility failed to assess the residents before and after dialysis. The facility failed to ensure licensed nurses had appropriate education to care for and assess residents who received dialysis for 26 out of 34 licensed nurses. Findings include:R1's hospital medical records dated 11/15/25 indicated R1 would be transferred to the facility after surgical repair of hip fracture after a fall at home. R1's additional diagnoses included end stage renal disease on dialysis and anemia in chronic kidney disease. The medical records indicated R1 would continue receiving hemodialysis through left arm fistula at an outside provider on Monday's, Wednesday's, and Friday's. R1's treatment administration record (TAR) dated 11/18/25 to 11/21/25 did not identify dialysis ongoing monitoring for complications before and after dialysis treatments. R1's progress notes from 11/18/25 to 11/21/25 indicated R1 attends dialysis on Monday, Wednesday, and Friday, dialysis access was on R1's AV fistula to left arm. On 11/19/26 indicated R1 was out to dialysis. No other data regarding R1's dialysis monitoring was documented. R1's care plan dated 11/19/25 indicated R1 needed dialysis related to end stage renal disease. R1's interventions were the nurse would not draw blood in arm with graft on her left upper extremity. The nursing assistants would not take R1's blood pressure on arm with graft in her left upper extremity. The nurse would monitor, document, and report to the healthcare provider as needed for signs and symptoms of bleeding, hemorrhage, bacteremia, and septic shock. The nurse would monitor, document, and report to the health care provider as needed for signs and symptoms of renal insufficiency included changes in level of consciousness, changes in skin turgor, oral mucosa, and changes in heart and lung sounds. The nurse would encourage R1 to go to his scheduled dialysis appointments. The nurse would monitor, document, and report to the healthcare provider signs and symptoms of depression and obtain an order for a mental health consult if needed. R1's minimum data set (MDS) dated [DATE] indicated R1 had active diagnoses of end stage renal disease and dependence on renal dialysis. R1's medical record did not indicate nurses completed a Clinical Monitoring-Dialysis UDA on 11/19/25. R5's progress notes dated 1/1/26 to 3/24/26 included R5's diagnosis of dependence on renal dialysis.-On 2/21/26 indicated diagnosis related to R5's skilled nursing stay included fluid overload, unspecified, indicated R5 was to continue dialysis per schedule. No other data regarding R5's dialysis monitoring was documented.-On 2/16/26 R5 was at dialysis.-On 2/13/26 R5 returned to the facility from dialysis, no new orders, vital signs normal, R5 was stable.-On 2/11/26 diagnoses relevant to the R5's skilled stay included dependence on renal dialysis. R5 returned from dialysis with no new orders, denied shortness of breath, no sign, or symptoms of discomfort.-On 2/9/26 diagnoses relevant to the R5's skilled stay included dependence on renal dialysis. R5 returned from dialysis with no new orders, denied shortness of breath, no sign, or symptoms of discomfort.-On 2/7/26 diagnoses relevant to the R5's skilled stay included dependence on renal dialysis.-On 2/6/26 R5 returned from dialysis with no new orders.-On 2/5/26 diagnoses relevant to the R5's skilled stay included dependence on renal dialysis.-On 2/4/26 Malnutrition diagnoses included receives dialysis 3x/week. R5 is weighed pre/post at dialysis. Noted variable hospital weights of 240 pounds (lbs), 260 lbs, 262 lbs, 268 lbs, 279 lbs. Unclear what is accurate. Initial weight here was incorrect, and writer struck out this wt. Noted post-dialysis weight of 258 lbs on 1-28-26. Used this weight in Section K of the admission MOS. Expect slight weight fluctuation in between dialysis runs.-On 2/2/26 diagnoses relevant to the R5's skilled stay included dependence on renal dialysis. R5 returned from dialysis with no new orders, denied shortness of breath, no sign, or symptoms of discomfort.-On 1/30/26 diagnoses relevant to the R5's skilled stay included dependence on renal dialysis. Age relates osteoporosis diagnosis includes R5 returned from dialysis today no new orders, denied SOB- No S/S of discomfort noted.-On 1/28/26 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5 returned from dialysis with no new order.-On 1/28/26 diagnoses relevant to the R5's skilled stay included dependence on renal dialysis. Need for assistance with personal care R5 returned from dialysis today no new orders, denied SOB- No S/S of discomfort noted.-On 1/26/26 diagnoses relevant to the R5's skilled stay included dependence on renal dialysis. Need for assistance with personal care R5 returned from dialysis today no new orders, denied SOB- No S/S of discomfort noted.-On 1/23/26 diagnoses relevant to the R5's skilled stay included dependence on renal dialysis. Age relates osteoporosis diagnosis includes R5 returned from dialysis today no new orders, denied SOB- No S/S of discomfort noted. R5's provider order dated 1/23/26 indicated R5 was to receive dialysis at an outside dialysis center on Mondays, Wednesdays, and Fridays. R5's dialysis treatment was to start at 2:15 p.m. R5's care plan dated 1/23/26 indicated R5 required dialysis related to end stage renal disease. R5's interventions included the nurse would monitor and document for peripheral edema. The nurse would monitor, document, and report to the health care provider as needed for signs and symptoms of bleeding, hemorrhage, bacteremia, and septic shock. The nurse would monitor, document, and report to the health care provider as needed for signs and symptoms of renal insufficiency included changes in level of consciousness, changes in skin turgor, oral mucosa, and changes in heart and lung sounds. The nurse would monitor, document, and report to the health care provider as needed for signs and symptoms of infection to the access site including redness, swelling, warmth, or drainage. The nurses or nurses' aides would observe for dry skin and apply lotion as needed. The nurse would monitor, document, and report to the healthcare provider signs and symptoms of depression and obtain an order for a mental health consult if needed. R5's MDS dated [DATE] indicated R5 was admitted to the facility with a primary diagnosis of fractures and other multiple traumas. R5's additional diagnosis included dependence on renal dialysis. The MDS indicated R5 was on dialysis. R5's treatment administration record (TAR) dated 3/1/26 to 3/31/26 did not identify dialysis ongoing monitoring for complications before and after dialysis treatments. R1's medical record did not indicate nurses completed a Clinical Monitoring-Dialysis UDA on 1/23/26, 1/26/26, 1/28/26, 1/30/26, 2/2/26, 2/4/26, 2/6/26, 2/9/26, 2/11/26, 2/13/26, 2/16/26, 2/18/26, 2/20/26, 2/23/26, 2/25/26, 2/27/26, 3/2/26, 3/4/26, 3/6/25, 3/9/26, 3/11/26, 3/13/26, 3/16/26, 3/18/26, 3/20/26, or 3/23/26. R7's progress notes dated 1/1/26 to 3/24/26 included R7's diagnosis of dependence on renal dialysis.-On 3/9/26 was at dialysis. Going to dialysis this morning and only having a cracker and apple juice.-On 3/6/26 R7 was at dialysis.-On 3/2/26 R7 was at dialysis.-On 2/23/26 R7 was at dialysis.-On 2/18/26 R7 was at dialysis.-On 2/16/26 R7 was at dialysis.-On 2/15/26 diagnoses relevant to the R7's skilled stay included weakness, continuedialysis three times per week.-On 2/14/26 diagnoses relevant to the R7's skilled stay included weakness, continuedialysis three times per week.-On 2/12/26 diagnoses relevant to the R7's skilled stay included weakness, continuedialysis three times per week. No c/o pain and returned from dialysis with no new orders. R7's provider order dated 2/9/26 indicated R7 was to receive dialysis at an outside dialysis center on Mondays, Wednesday's, and Fridays. R7 was to use an outside transportation company to bring him from the facility to the outside dialysis center. R7's care plan dated 2/10/26 indicated R7 required dialysis related to end stage renal disease. R5's interventions included the nurse would monitor and document for peripheral edema. The nurse would monitor, document, and report to the health care provider as needed for signs and symptoms of bleeding, hemorrhage, bacteremia, and septic shock. The nurse would monitor, document, and report to the health care provider as needed for signs and symptoms of renal insufficiency included changes in level of consciousness, changes in skin turgor, oral mucosa, and changes in heart and lung sounds. The nurse would encourage R7 to go to his scheduled dialysis appointments. The nurse would monitor, document, and report to the health care provider as needed for signs and symptoms of infection to the access site including redness, swelling, warmth, or drainage. The nurse would monitor, document, and report to the healthcare provider signs and symptoms of depression and obtain an order for a mental health consult if needed. R7's MDS dated [DATE] indicated R7 was (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted to the facility with a primary diagnosis of medically complex conditions. R7's additional diagnoses included chronic kidney disease stage 3B and dependence on renal dialysis. R7's treatment administration record (TAR) dated 3/1/26 to 3/31/26 did not identify dialysis ongoing monitoring for complications before and after dialysis treatments. R7's medical record did not indicate nurses completed a Clinical Monitoring-Dialysis UDA on 2/11/26, 2/13/26, 2/16/26, 2/18/26, 2/20/26, 2/23/26, 2/25/26, 2/27/26, 3/2/26, 3/4/26, 3/6/25, 3/9/26, 3/11/26, 3/13/26, 3/16/26, 3/18/26, 3/20/26, or 3/23/26. Personnel record review indicated for licensed practical nurse (LPN)-A, LPN-C, LPN-D, LPN-E, LPN-F, RN-A, RN-B, RN-D, RN-F, RN-G, RN-I, RN-J, RN-K, RN-L, RN-M, RN-N, RN-O, RN-Q, RN-R, RN-S, RN-T, RN-U, RN-V, RN-X, RN-Y, or RN-BB, did not have an onboarding orientation checklist that identified dialysis education. During an interview on 3/23/26 at 9:44 a.m., registered nurse (RN)-A stated the only complication she looks for on a dialysis resident is bleeding from the access site. RN-A stated she does not recall having training on residents who receive dialysis treatment. During an interview on 3/24/26 at 9:27 a.m., R7 stated nurses do not check their access site before and after his dialysis treatment. R7 stated the nurse does not complete an assessment when he comes back from dialysis. During an interview on 3/24/26 at 10:08 a.m., the administrator stated licensed nurses do not receive education on residents receiving dialysis treatment at a corporate level but states the nurses may get training when they first start at the facility. During an interview on 3/24/26 at 10:17 a.m., RN-D stated the only complication a resident can have when receiving dialysis treatment is change in vital signs. RN-D stated she takes the resident's vitals before the resident goes to dialysis, but states that she takes vitals on all residents in the morning. RN-D stated that after a resident comes back from dialysis, she will take the resident's vitals but does not complete any other assessment. RN-D stated the only education she received regarding dialysis resident was to take the resident's vitals after they come back from dialysis. During an interview on 3/24/26 at 10:46 a.m., the clinical learning and development specialist (CLDS) stated licensed nurses do not receive education on dialysis residents. The training happens once the nurse is at the facility, and it is specific to each facility whether the nurses get training or not. Once a resident comes back from dialysis treatment, the expectation is that the nurse will complete a dialysis assessment in the resident's chart. The dialysis assessment consists of getting the resident's full set of vitals including weight, pedal pulses, pain levels, checking the shunt and brill, and fluid and food intake and output. If the resident comes back from dialysis with new orders, those orders would be placed in the dialysis assessment. CLDS stated it is the responsibility of the nurse to go into the resident's assessments and complete the dialysis assessment; the dialysis assessment is not an automatic prompted assessment. CLDS stated if the dialysis assessment is not completed and documented, that would indicate to her that the dialysis assessment was not completed. During an interview on 3/24/26 at 12:07 p.m., RN-E stated when a resident returns from dialysis, it is the expectation that the nurse completes a dialysis assessment. RN-E stated if there is not a dialysis assessment in the resident's chart, it would mean to her that the dialysis assessment was not completed. RN-E stated, I know that the facility dropped the ball on educating the nurses. The facility's Clinical Monitoring- Dialysis UDA assessment consists of vital signs including most recent weight, blood pressure-lying, blood pressure- sitting, most recent blood pressure, blood pressure-standing, most recent temperature, most recent pulse, most recent pedal pulse- left, most recent pedal pulse- right, most recent respirations, most recent blood sugar, most recent oxygen saturations, most recent pain level, non-medication pain interventions and effectiveness, pain medications administered and effectiveness, checking the shunt bruit, checking the shunt thrill, fluid intake for current shift, fluid output for current shift, and if the resident's fluid restrictions were maintained. The facility's Dialysis Services policy dated 9/30/25 indicated the Clinical Monitoring-Dialysis UDA assessment is available in the computer system for use in monitoring the resident's receiving dialysis.