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	05/12/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and documentation, the facility failed to assess and monitor non-pressure skin conditions for 2 of 3 residents (R1 and R2) reviewed for skin management.R1R1's admission Minimum Data Set (MDS) dated [DATE], 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 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 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 (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. R2R2's admission MDS dated [DATE], 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 [DATE], indicated R2 had a bruise above right elbow which measured 1 cm (centimeter) in length.R2's Skin Issues assessment dated [DATE], 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.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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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.-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 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 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 [DATE] and discharge on [DATE], 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 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.R2R2's admission MDS dated [DATE], 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, (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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. R3R3's admission MDS dated [DATE], 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 (continued on next page)

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	245221	A. Building B. Wing	05/12/2026

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 includeR1's admission Minimum Data Set (MDS) dated [DATE], 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 [DATE], 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.R2R2's admission MDS dated [DATE], 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.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 medicationDuring 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 [DATE], 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 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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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 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 [DATE], 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 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.