

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885</p> <p>Based on observation, interview, and document review, the facility failed to ensure reclining foot rests functioned appropriately for 1 of 1 resident (R212) and failed to ensure a clean communal shower room which had the potential to affect all residents who used the shower room.</p> <p>Findings include,</p> <p>R212's comprehensive Minimum Data Set (MDS) in progress dated 8/15/24, indicated intact cognition, had coronary artery disease and hypertension (high blood pressure), acute myocardial infarction (heart attack), presence of an aortocoronary bypass graft, and had an encounter for surgical after care following surgery on the circulatory system.</p> <p>R212's physician orders form indicated the following order:</p> <p>8/16/24, bumetanide 1 milligram (MG) by mouth daily for edema (fluid collecting in body tissues) and shortness of breath.</p> <p>R212's care plan dated 8/12/24, identified R212 took a diuretic.</p> <p>During interview on 8/19/24, at 1:13 p.m., R212 stated she mentioned to a few staff that the recliner chair did not work when trying to put her feet up, the foot rest would not stay in the upright position. R212 stated she mentioned the concern on 8/18/24, and again the morning of 8/19/24.</p> <p>During interview on 8/21/24 at 7:18 a.m., the manager of ancillary services (MOAS)-A stated he becomes aware of repairs thru the use of a maintenance slip or if there is something more severe or if something was urgent, a direct phone call was completed. MOAS-A further stated maintenance slips were used for everything to make him aware. A list of maintenance slips were requested from the past three weeks including completed orders and uncompleted work orders.</p> <p>During interview on 8/21/24 at 7:43 a.m., the MOAS-A provided the maintenance slips and further stated if in a hurry, instructs to fill out a slip, but if it is something like a remote not working, MOAS-A will look at the remote and not necessarily fill out a slip, but if a slip is not filled out, will look at the issue immediately or the same day. The work orders lacked information regarding R212's reclining chair.</p> <p>(continued on next page)</p>

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: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview and observation on 8/21/24 at 11:39 a.m., nursing assistant (NA)-B answered R212's call light and pulled the lever to recline R212 in the recliner chair. The foot rest would not stay in the elevated position. NA-B stated when the back of the chair is pulled back, the chair wouldn't stay in a reclined position and stated a lot of the chairs this style have been doing this since they got them and stated R212 had been wanting a new chair and stated somebody told R212 on 8/20/24, that they could not interchange the chairs, but did not know who told R212 the chairs could not be changed. NA-B further stated R212 mentioned the chair issue to her 8/20/24, but did not talk to maintenance. R212 stated she had swelling in her feet.</p> <p>During interview on 8/21/24, at 11:45 a.m., and 11:47 a.m., registered nurse (RN)-B stated if a recliner chair wasn't functioning, they contacted maintenance who will repair or replace a chair. RN-B stated she was not aware R212's leg rest on the chair was not functioning. RN-B stated MOAS-A was pretty quick and usually came up on the same day of any requests. RN-B further stated R212 had heart surgery and it would be important to elevate her legs for the swelling and edema. At 11:47 a.m., RN-B called and notified MOAS-A that R212's recliner chair was not working and would come up to look at the chair.</p> <p>During interview on 8/21/24 at 2:21 p.m., NA-B stated R212 was able to respond appropriately and could make her needs known.</p> <p>During interview on 8/22/24 at 7:33 a.m., MOAS-A stated the recliners had two springs that held the leg rest up and the manufacturer provided springs in three different tensions and stated the stiffness of the springs were used based on a resident's weight and residents used their legs and the lever to put their legs down, but if they don't have the strength, adjustments are made with a different tension spring. MOAS-A stated he did not know how long R212 had the problem and was first made aware of it around 12:00 p.m., on 8/21/24.</p> <p>During interview and observation 8/22/24 at 10:51 a.m., R212 was able to recline herself in the reclining chair and put the foot rest down and stated it was much better.</p> <p>During interview on 8/22/24 at 12:00 p.m., the director of nursing (DON) stated she expected staff to complete a slip to notify maintenance and further stated she expected staff to contact maintenance and stated she would contact MOAS-A to see if there was a schedule for the shower room and expected housekeepers keep a schedule.</p> <p>44647</p> <p>R13's quarterly MDS dated [DATE], indicated R13 was cognitively intact and had diagnoses of heart failure and diabetes. Furthermore, R13's MDS indicated R13 required partial/moderate assistance to shower.</p> <p>When interviewed on 8/19/24 at 12:18 p.m., R13 was seated in their wheelchair in the room. R13 stated there was mold growing in the shower room. R13 stated she had reported it before about a year ago and it was cleaned up and looked great however it was returning. R13 stated it was between the tiles and along the edges of the floor.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 8/19/24 at 12:26 p.m., the lower-level shower room for the odd number hallway was observed. The room had a small ivory/white tiled floor. Grout in between the tiles were whit/light colored in most of the areas. However, several areas of the floor had darker black grout between the tiles.</p> <p>An observation on 8/21/24 at 12:28 p.m., the lower-level shower room for the even number hallway was observed. The room had a small ivory/white tiled floor. There was dark grout in between the tiles under the shower and along the shower floor and wall.</p> <p>When interviewed on 8/21/24 at 12:11 p.m., housekeeper (HSK)-A stated shower rooms were cleaned daily, and maintenance completed any deep cleaning and was not aware of any schedule for deep cleaning. HSK-A stated the shower room on the odd hallways did not get used much and most residents used the even hall shower. HSK-A was aware of the black grout between the tiles and along the wall and stated the mop used did not get in deep and mostly cleaned the surface of the tiles. HSK- stated they have tried to use their fingernail over the mop sponge to try to dig in between the tiles some, but it was hard to get it removed.</p> <p>When interviewed on 8/21/24 at 12:28 p.m., the MOAS-A verified the dark grout on the tile floor in the even number shower room and stated they needed to have a deep clean. MOAS-A further stated there was not a routine deep cleaning schedule and it was just as needed. MOAS-A was not aware of them needing cleaning and was not sure when the last time it was done. MOAS-A was able to confirm the shower rooms have not been deep cleaned in the past 8 months since their return.</p> <p>A policy, Resident Environment, dated 2/2/24, indicated the facility will provide a safe, clean, comfortable environment that allows the residents use of some personal belongings. Resident rooms will be designed and equipped for adequate nursing care, safety and comfort and will ensure full visual privacy for each resident as well as the following, housekeeping and maintenance services and functional furniture appropriate to resident needs.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885</p> <p>Based on interview and document review the facility failed to ensure comprehensive care plans were developed for 1 of 1 resident (R50) and failed to ensure non-pharmacological interventions were developed and implemented for 1 of 1 resident (R110) reviewed for psychotropic drug use.</p> <p>Findings include:</p> <p>R50's admission Minimum Data Set, dated dated [DATE], indicated severe cognitive impairment, did not have little interest or pleasure in doing things, and did not feel down, depressed, or hopeless, did not have physical, verbal, or other behaviors, had diagnoses of dementia and depression and took an antipsychotic and antidepressant medication.</p> <p>R50's care area assessment (CAA) worksheet dated 7/16/24, indicated R50 took duloxetine (an antidepressant) and aripiprazole (an antipsychotic) for depression and psychotropic drug use would be addressed in the care plan in order to minimize risks.</p> <p>R50's physician orders indicated the following orders:</p> <p>7/4/24, aripiprazole 20 milligrams (MG) by mouth once daily.</p> <p>7/4/24, duloxetine 30 mg by mouth every evening, and 60 mg by mouth every morning. R50's orders lacked any monitoring for side effects of duloxetine and aripiprazole.</p> <p>R50's care plan was reviewed and lacked information R50 had a specific care plan for depression, and further lacked any monitoring for side effects of duloxetine and aripiprazole.</p> <p>R50's Pharmacist Medication Review form dated 8/15/24, indicated R50 was on Aspirin 325 mg daily indicated Aspirin was indicated for the prevention and or treatment of a wide variety of cardiovascular condition, and there was general consensus across guidelines that when used for primary or secondary cardiovascular prevention, lower doses of Aspirin have similar efficacy to higher doses, but carry less risk for significant bleeds. Please consider lowering this patient's Aspirin to 81 mg daily. The review lacked information for monitoring for side effects of aripiprazole or duloxetine.</p> <p>R50's Pharmacist Consultant review dated 7/19/24 indicated R50 was on aripiprazole 20 mg daily, please order monthly orthostatic blood pressure monitoring.</p> <p>R50's Pharmacist Consultant review dated 7/4/24 indicated no potential clinically significant medication issues identified at this time.</p> <p>During interview on 8/21/24 at 11:15 a.m., the consulting pharmacist (CP)-A stated antidepressant side effect monitoring included monitoring for central nervous system changes, whether a resident starts falling, weight loss and weight gain and further stated specific manifestations can take a few weeks and did not see any specific orders for R50.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 8/21/24 at 12:03 p.m., registered nurse (RN)-C stated if a resident was on a psychotropic medication, it was added to the careplan and any monitoring for side effects showed up in the medication administration records. RN-C viewed the orders and stated R50 should have monitoring because R50 was on aripiprazole and duloxetine and verified the orders lacked monitoring and further RN-C viewed R50's care plan and verified R50 did not have a care plan related to psychotropics. RN-C also viewed R50's discontinued orders and verified there were no orders for monitoring and stated it should be there and would have to follow up with the director of nursing.</p> <p>During interview on 8/21/24 at 11:49 a.m., nursing assistant (NA)-B stated she would have to ask the nurse to see what kind of medications a resident was on and could also look in the Kardex to see if there were any behaviors to watch for.</p> <p>During interview on 8/22/24 at 12:13 p.m., the director of nursing (DON) stated monitoring was completed weekly and should be part of the documentation and whether the medications are effective and stated monitoring was supposed to be in the nursing orders and checked the care plan and verified the care plan lacked information R50 was on aripiprazole and duloxetine or had any kind of monitoring in place.</p> <p>42586</p> <p>R110's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, diagnosis of Bipolar disorders, was independent to supervision with ADL's and received an antipsychotic on a routine basis.</p> <p>R110's care area assessment (CAA) worksheet for psychotropic drug use dated 8/7/24, indicated: R110 received an antipsychotic, antidepressant, and hypnotic medication. Resident for drug induced Parkinsonism, multiple falls, chronic back pain, and myelofibrosis for diagnosis of bipolar disorder. Resident appears to tolerate medication without adverse reaction. Nursing staff observe for mood and behavior, and potential adverse reaction with administration of medication.</p> <p>R110's physician's orders dated 8/1/24, indicated olanzapine oral tablet 15 milligrams (mg). Give 15 mg by mouth at bedtime for psychosis.</p> <p>R110's care plan dated 8/5/24, indicated R110 was on antipsychotic medication therapy related to bipolar and psychosis. It further contained the following interventions:</p> <ul style="list-style-type: none"> -R110 will be free of any discomfort or adverse side effects from antipsychotic medication use through the review date. -monitor resident condition based on clinical practice guidelines or clinical standards of practice related to use of (olanzapine). -consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate. -WARNINGS #1: Refer to boxed warnings in the orders or eMAR, or medication reference of choice <p>R110's care plan lacked any indication of non-pharmacological interventions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 8/22/24 at 9:15 a.m., nurse manager registered nurse (RN)-A stated when a resident comes in as a new admission a baseline care plan was initiated by the admitting nurse, MDS nurse or the DON. After that they continue to develop a more comprehensive care plan which was driven by the admission assessment. As things change, the care plan was continuously updated and the MDS nurse had a huge part in that but all departments are included. RN-A further stated staff should be developing and impletmenting non-pharmacological interventions on the care plan for residents who receive an antipsychotic medication and verified R110's care plan lacked individualized non pharmacological interventions.</p> <p>During interview on 8/22/24 at 2:19 p.m. the director of nursing (DON) stated non pharmacologic interventions should be developed, monitored, care planned and documented for residents who receive an antipsychotic medication.</p> <p>A policy, Care Plan-R/S, LTC, Therapy & Rehab, dated 11/1/23, indicated the purpose was to develop a comprehensive care plan using an interdisciplinary team approach, to provide guidance to the interdisciplinary team (IDT) in developing the initial care plan. The comprehensive care plan includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647</p> <p>Based on observation, interview, and record review the facility failed to ensure routine incontinent care was provided for 1 of 3 residents (R18) reviewed for dependent activities of daily living (ADL's).</p> <p>Findings include:</p> <p>R18's quarterly Minimum Data Set (MDS) dated [DATE], indicated R18 had cognitive impairment and diagnoses of heart disease, Alzheimer's Disease, and anxiety disorder. R18's MDS also indicated R18 was always incontinent of bladder and bowel and required maximal assistance from staff for incontinent cares.</p> <p>R18's care plan revised 4/3/24, indicated R18 had incontinence related to impaired mobility, weakness, and use of a diuretic. Interventions included to monitor for signs of urinary tract infection, use incontinence products, check for incontinence frequently and provide brief change and incontinence cares as needed.</p> <p>R18's Kardex printed 8/20/24, indicated R18 required frequent checks for incontinence and assistance with incontinence cares.</p> <p>A continuous observation on 8/20/24 at 10:58 a.m., R18 was in their room seated in a broada wheelchair. R18 was slightly reclined, and the feet were not elevated. In front of R18 was the bedside table. At 11:58 a.m. , the resident remained in the same position and no staff had entered the room. At 12:123 p.m., nursing assistant (NA)-A entered R18's room with their lunch tray. T NA-A obtained a chair and assisted R18 with lunch. At 12:30 p.m., NA-A cleaned up R18 and removed the lunch tray leaving the remainder of the juice and water on R18's tray in front of them. NA-A had left R18's room without providing repositioning or checking for incontinence. At 12:55 p.m., housekeeper (HSK)-A entered R18's room for room cleaning. A At 1:10 p.m., hsk-A had completed cleaning R18's room. At 1:28 p.m., no other staff had entered R18's room to offer repositioning or check for incontinence care. At 1:35 p.m., NA-B had entered R18's room and removed the pillow and reclined R18 all the way back in the broada chair. R18's feet were now elevated. NA-B had not asked or offered R18 incontinent cares.</p> <p>When interviewed on 8/20/24 at 1:40 p.m., NA-B stated the Kardex, and care plan gave information about the cares residents need. NA-B was not sure if R18 had any skin concerns or was at risk for breakdown but knew R18 was usually reclined after lunch and should be repositioned every 2 hours. NA-B further stated NA-A usually did not work on this unit and they understood R18's routine a little better. NA-B verified they did not check or ask R18 about incontinence.</p> <p>When interviewed on 8/20/24 at 1:55 p.m., NA-A stated R18 was incontinent and required total assistance with repositioning and ADLs. R18 required a hoyer lift to get in and out of bed and should be repositioned and checked for incontinence about every 2 hours. NA-A verified they had not offered repositioning after lunch as she appeared to be resting comfortably. NA-A further stated R18 had not been checked for incontinence or changed since before lunch and stated was going to go do that now.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 8/20/24 at 2:03 p.m., NA-A and licensed practical nurse (LPN)-A entered to assist R18 back to bed. Hand hygiene was performed upon entrance and gloves were donned however NA-A and LPN-A had not donned a gown. R18 was lifted with the Hoyer lift and placed in bed. NA-A removed R18's slippers. R18 had knee high nylon stockings in place and was wearing a nightgown/dress. NA-A unfastened R18's brief and tucked it down. NA-A provided cares from the front before LPN-A assisted to turn R18 to the side. NA-A removed R18's wet brief. R18's bottom had blanchable redness and skin was intact. R18 cleaned R18 from the back side and removed gloves. NA-A applied barrier cream before placing a clean brief and assisted R18 to roll on their back. LPN-A pulled the brief through and secured. NA-A adjusted R18 to tilt to their right side and covered up.</p> <p>When interviewed on 8/20/24 at 2:20 p.m., LPN-B stated R18 had fragile skin and was prone to skin breakdown. R18 required frequent position changes and heels elevated. LPN-B stated R18 was dependent with ADLs and was incontinent. LPN-B stated incontinent cares or checks should be completed every couple hours, or when R18 was repositioned.</p> <p>When interviewed on 8/21/24 at 2:19 p.m., registered nurse (RN)-A stated repositioning and incontinent cares should happen frequently for R18 as R18 was at risk for skin breakdown. RN-A stated there wasn't a specific time frame, but multiple times a shift.</p> <p>When interviewed on 8/22/24 at 2:19 p.m., the Director of Nursing (DON) stated incontinence cares were not completed on a specific timeframe but generally residents should check in the morning, after breakfast, before lunch, etc. The checks are individualized to the resident and should be included on the care plan.</p> <p>A facility policy for incontinent/ADL cares was requested however was not recieved.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647</p> <p>Based on observation, interview, and record review the facility failed to ensure 3 of 4 residents (R18, R4, R12) reviewed for skin alterations had weekly skin observations completed. Furthermore, the facility failed to ensure bruising was assessed and monitored for 1 of 3 resident (R12) reviewed for bruising and a skin tear was assessed and monitored for 1 of 2 residents (R18) reviewed for pressure injury.</p> <p>Findings include:</p> <p>R18's quarterly Minimum Data Set (MDS) dated [DATE], indicated R18 had cognitive impairment and diagnoses of heart disease, Alzheimer's Disease, and anxiety disorder. R18's MDS also indicated R18 was at risk for pressure injury, was always incontinent of bladder and bowel, and was dependent on staff for mobility.</p> <p>R18's care plan revised 4/3/24, indicated R18 had potential for pressure ulcer development related to impaired mobility, weakness, history of falls, and use of a diuretic. R18 further had a known pressure insult of suspected deep tissue injury to both heels. Interventions included to assist to turn/reposition with a goal of every 2 hours, float heels off bed, provide pressure reducing mattress and gel cushion in wheelchair, and notify the nurse immediately of any new skin breakdown.</p> <p>R18's Kardex printed 8/20/24, indicated R18 was a high risk for skin injury and had history of previous skin breakdowns. Staff were directed to notify the nurse of any new areas, redness, blisters, or bruises noted during care activities.</p> <p>R18's medical record lacked indication R18 had a weekly skin observation completed since 7/25/24.</p> <p>R18's nursing and provider orders lacked indication R18 required monitoring or treatment to the right lower extremity</p> <p>skin alteration on the skin.</p> <p>R18's medical record lacked evidence R18's skin tear had been assessed until 8/20/24 (after entrance).</p> <p>An observation on 8/20/24 at 2:03 p.m., NA-A and licensed practical nurse (LPN)-A entered to assist R18 back to bed. R18 had knee high nylon stockings in place and was wearing a nightgown/dress. Under the stockings on R18's right shin, steri-strips were in place to close a skin alteration. LPN-A was not sure what the wound on R18's right shin was from and would check with LPN-B.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>When interviewed on 8/20/24 at 2:20 p.m., LPN-B stated R18 had fragile skin and was prone to skin breakdown. R18 required frequent position changes and heels elevated. LPN-A stated skin observations were completed on shower days and verified R18 had not had a skin observation documented since 7/25/24. LPN-A was not sure why R18 had steri-strips on the right shin and was not able to find any documentation in R18's record of when or how it happened. There should be an incident report and documentation. LPN-B reviewed the 24-hour nurse book and verified there was not anything listed there either.</p> <p>When interviewed on 8/21/24 at 2:19 p.m., registered nurse (RN)-A stated staff should be completing skin observations and reporting any new skin alterations so the correct follow up was in place. RN-A stated it appeared to be a skin tear and treatment was provided and was following up with staff to find out more details. RN-A verified there was no skin observations completed by staff since 7/25/24 and they should have been completed or documentation of refusal.</p> <p>When interviewed on 8/22/24 at 2:19 p.m., the Director of Nursing (DON) expected staff to complete weekly skin observations weekly with bathing. Nurses should also assess and document any skin alterations when they occur.</p> <p>42586</p> <p>R4's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg below the knee, and type II diabetes mellitus with diabetic chronic kidney disease. It further indicated, impairment on one side of lower extremity, required staff assistance with most activities of daily living (ADL) and mobility, had a surgical wound, and no rejection of care behaviors were noted.</p> <p>R4's physician's order dated 6/20/24, indicated to complete skin user data assessment (UDA) or daily skilled note regarding skin condition on bath day-Thursday morning. Please check entire body for any skin insults or new skin injury and report to nurse manager or wound team every day shift every Thursday for skin care. In addition, another physician's order dated 8/13/24, indicated wound care right leg: cleanse the wound using wound cleanser. Apply Vashe-moistened gauze, let sit 10 minutes, then remove and pat dry. Protect the skin around the wound with Cavilon barrier film. Apply medihoney alginate, cut to fit the size of the wound and place directly over wound followed by 4X4 silicone foam adhesive (zetuvit border) is covered for daily dressings. Moisturize legs daily with thick, hypoallergenic, high quality moisturizer (CeraVe, Eucerin, Cetaphil, Vanicream). Apply every day shift every other day for wound care</p> <p>R4's care plan dated 6/18/24, indicated R4 had an amputation of right below knee with the following interventions:</p> <ul style="list-style-type: none"> -check and document on wound daily for signs/symptoms of infection, drainage, bleeding, any breakdown of skin and impaired circulation (edema or pain). -monitor/document pain management. Document frequency, duration, intensity of pain, phantom pain. Report to health care provider if medications are not effective. -monitor for excessive wound drainage, swelling, redness, etc. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-monitor for bleeding and document.</p> <p>R4's medical record lacked any indication of weekly skin assessments.</p> <p>R4's progress notes for July and August 2024, lacked documentation of weekly skin assessments.</p> <p>During interview on 8/21/24 at 2:06 p.m., registered nurse (RN)-C verified there was no documentation of weekly skin assessments for the surgical incision on R4's right leg and there should have been. The skin assessment should include (at a minimum) a description of the wound in a progress note.</p> <p>R12</p> <p>R12's significant change Minimum Data Set (MDS) dated [DATE], indicated, intact cognition and diagnoses of displaced bicondylar fracture of right tibia, atrial fibrillation, and chronic kidney disease (CKD). It further indicated R12 required assistance from staff with most activities of daily living (ADL), mobility, and received an anticoagulant on a routine basis.</p> <p>R12's physician's order dated 5/10/24, indicated please complete skin assessment UDA or daily skilled note regarding skin condition on this bath day-Friday PM. Please check entire body for any skin insults or new skin injury and report to nurse manager or wound team every evening shift every Friday for skin care.</p> <p>R12's care plan dated 5/6/24, indicated R12 was on anticoagulant therapy. Report to nurse observations of blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs, etc. It further indicated the following interventions:</p> <p>-monitor resident condition based on clinical practice guidelines or clinical standards of practice related to use of (apixaban).</p> <p>-Teaching: Resident/family/caregiver teaching to include the following: take/give medication at the same time each day; use soft toothbrush; use electric razor; avoid activities that could result in injury; take precautions to avoid falls; s/s of bleeding; avoid foods high in Vitamin K (includes greens such as spinach and turnips, asparagus, broccoli, cabbage, Brussel sprouts, milk, and cheese).</p> <p>-WARNINGS #1: Refer to boxed warnings in the orders or electronic medication administration record (eMAR), or medication reference of choice.</p> <p>R12's medical record lacked any indication of weekly skin assessments.</p> <p>R12's progress notes for July and August 2024, lacked documentation of weekly skin assessments.</p> <p>During observation and interview on 8/19/24 at 1:37 p.m., R12 stated her wheelchair was too narrow and the arm rests were too high. She then showed surveyor a bruise on the inside of her upper right arm which was dark purple in color and appeared to line up with height of arm rest. R12 further stated she was on a blood thinner (Eliquis) and she had reported it to the lady at the front desk.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During observation and interview on 8/20/24 at 7:59 a.m., R12 was sitting in her wheelchair in her room. She had a large purple bruise on her inner arm by the elbow (from a hospital blood draw) and another smaller purple bruise next to it that she stated she had bumped on the arm rest of her wheelchair and demonstrated where it matched up. RN-D verified the bruise and stated she wasn't aware of it and it should have been documented in R4's chart and monitored until it was resolved.</p> <p>During interview on 8/22/24 at 9:15 a.m., nurse manager registered nurse (RN)-A stated the nurses were responsible to document and monitor skin alterations such as bruises and scratches. They also need to try to identify where they came from and depending on the answer, may need to fill out an incident report or a progress noted. RN-A further stated skin assessments should be completed weekly and documented in a UDA or progress note stating I would like to see them follow it until it has resolved. RN-A verified R4 had a surgical incision on her right leg and didn't see any weekly skin assessments with a description of the incision which was important because it was hard to monitor what was going on without a description. She also verified R12's last skin assessment was on 8/9/24 and there haven't been any skin assessments since then.</p> <p>During interview on 8/22/24 at 2:19 p.m., the director of nursing (DON) stated skin assessments should be completed by nurses weekly and as needed and documented until resolved. If the skin alteration was a surgical incision, she would expect the nurse to monitor for healing, signs/symptoms of infection, drainage, proper closure, etc. and simply documenting the dressing was intact was not enough to be considered proper documentation</p> <p>A facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation revised 4/26/24, directed staff notify the nurse immediately about monitor any bruise, contusion, abrasion, or skin tear noted during cares. Furthermore, the policy directed staff to monitor any bruise, contusion or skin tear weekly and update the resident's care plan.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647</p> <p>Based on observation, interview, and record review the facility failed to ensure 1 of 2 residents (R18) who were at risk for pressure ulcers were repositioned in a timely manner to prevent pressure injury.</p> <p>Findings include:</p> <p>R18's quarterly Minimum Data Set (MDS) dated [DATE], indicated R18 had cognitive impairment and diagnoses of heart disease, Alzheimer's Disease, and anxiety disorder. R18's MDS also indicated R18 was at risk for pressure injury and was dependent on staff for mobility.</p> <p>R18's skin Care Area Assessment (CAA) indicated R18 was at risk for pressure injury due to immobility and weakness.</p> <p>A review of R18's nursing and provider orders showed:</p> <ul style="list-style-type: none"> -on 3/21/24, R18 required cleansing and barrier cream to be applied to wounds on the right buttock and posterior thigh. -on 7/24/24, R18 required cleaning and skin prep applied to the right heel daily. <p>R18's weekly skin observation dated 7/25/24, indicated R18 had a healing right heel wound and no other skin concerns. R18's medical record lacked evidence weekly skin observations had been completed since 7/25/24.</p> <p>R18's care plan revised 4/3/24, indicated R18 had potential for pressure ulcer development related to impaired mobility, weakness, history of falls, and use of a diuretic. R18 further had a known pressure insult of suspected deep tissue injury to both feels. Interventions included to assist to turn/reposition with a goal of every 2 hours, float heels off bed, provide pressure reducing mattress and gel cushion in wheelchair, and notify the nurse immediately of any new skin breakdown.</p> <p>R18's Kardex printed 8/20/24, indicated R18 was a high risk for skin injury and had history of previous skin breakdowns. Staff were directed to notify the nurse of any new areas, redness, blisters, or bruises noted during care activities.</p> <p>When interviewed on 8/19/24, at 1:13 p.m., R18 was in a manual wheelchair with the legs elevated straight out. Pillows were positioned under R18's legs. R18's lunch was sitting in front on the bedside table. R18 stated I have been sitting here for so long it hurts. At 1:20 p.m., health information management (HIM) came in to assist. R18 told HIM Sitting up too long and it hurts.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A continuous observation on 8/20/24 at 10:58 a.m., R18 was in their room seated in a broada wheelchair. R18 was slightly reclined, and the feet were not elevated. In front of R18 was the bedside table. At 11:58 a.m. , R18 remained in the same position and no staff had entered the room. At 12:123 p.m., nursing assistant (NA)-A entered R18's room with their lunch tray. The lunch tray was set down on the bedside table and a pillow was placed behind R18's shoulders/back to help R18 sit up a bit more. R18's broada chair had not been adjusted. NA-A obtained a chair and assisted R18 with lunch. At 12:30 p.m., NA-A cleaned up R18 and removed the lunch tray leaving the remainder of the juice and water on R18's tray in front of them. NA-A had left R18's room without providing repositioning or checking for incontinence. At 12:55 p.m., housekeeper (HSK)-A entered R18's room for room cleaning. At 1:10 p.m., hsk-A had completed cleaning R18's room. At 1:28 p.m., no other staff had entered R18's room to offer repositioning or check for incontinence care. At 1:35 p.m., NA-B had entered R18's room and removed the pillow and reclined R18 all the way back in the broada chair. R18's feet were now elevated. R18 had not been repositioned for 2 hours and 40 minutes.</p> <p>When interviewed on 8/20/24 at 1:40 p.m., NA-E stated the Kardex, and care plan gave information about the cares residents need. NA-E was not sure if R18 had any skin concerns or was at risk for breakdown but knew R18 was usually reclined after lunch and should be repositioned every 2 hours. R18 did not like too many pillows and was repositioned by tilting the wheelchair back. NA-E verified R18 required to be reclined so their feet were then elevated for it to be considered a change in position. NA-E further stated NA-E usually did not work on this unit and they understood R18's routine a little better.</p> <p>When interviewed on 8/20/24 at 1:55 p.m., NA-A stated R18 required total assistance with repositioning and ADLs. R18 required a hoyer lift to get in and out of bed and should be repositioned about every 2 hours. NA-A verified they had not offered R18 to be repositioned after lunch as she appeared to be comfortable.</p> <p>An observation on 8/20/24 at 2:03 p.m., NA-A and licensed practical nurse (LPN)-A entered to assist R18 back to bed. LPN-A assisted to turn R18 to the side. NA-A removed R18's wet brief. R18's bottom had blanchable redness and skin was intact. NA-A and LPN-A finished cares and then tilted R18 to her right side and covered her up.</p> <p>When interviewed on 8/20/24 at 2:20 p.m., LPN-B stated R18 had fragile skin and was prone to skin breakdown. R18 required frequent position changes and heels elevated. LPN-B did not think R18 was in the same position for long periods of time. LPN-B stated skin observations were completed on shower days and verified R18 had not had a skin observation documented since 7/25/24. LPN-B was going to complete a skin observation today.</p> <p>When interviewed on 8/21/24 at 2:19 p.m., registered nurse (RN)-A stated staff should be completing skin observations and reporting any new skin altercations so the correct follow up was in place. RN-A stated repositioning and incontinent cares should happen frequently for R18 and wasn't sure about an exact time frame, but multiple times a shift.</p> <p>When interviewed on 8/22/24 at 2:19 p.m., the Director of Nursing (DON) expected staff to complete weekly skin observations weekly with bathing. Nurses should also assess and document any skin alterations when they occur. DON further stated residents should not be in one position for long periods of time and repositioning frequency should be on the care plan and Kardex.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation revised 4/26/24, directed staff to develop an individualized repositioning schedule for residents unable to position themselves. This positioning placed should be communicated to the nursing assistants using the Kardex.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647</p> <p>Based on observation, interview and record review, the facility failed to ensure speech therapy recommendations were followed for 1 of 3 residents (R18) reviewed for nutrition.</p> <p>Findings include:</p> <p>R18's quarterly Minimum Data Set (MDS) dated [DATE], indicated R18 had cognitive impairment and diagnoses of heart disease, Alzheimer's Disease, and anxiety disorder. R18's MDS also indicated R18 had no signs or symptoms of a swallowing disorder and required set up and clean up for meals.</p> <p>R18's diagnoses list printed on 8/20/24, indicated R18 had a secondary diagnosis of dysphagia (impaired swallowing).</p> <p>R18's hospital discharge summary dated 6/14/21, indicated R18 had been hospitalized for an ankle fracture. R18 was assessed by speech therapy for dysphagia and had recently advanced to thin liquids and no straws.</p> <p>R18's hospital discharge orders dated 6/14/21, indicated R18 required a regular diet with thin liquids and no straws.</p> <p>R18's discharge orders also indicated R18 to follow speech therapy.</p> <p>R18's provider order dated 6/14/21, indicated R18 required a regular diet thin liquids and no straws.</p> <p>R18's food and nutrition data collection dated 8/3/24, indicated R18 had a regular diet and required a cup with lid, but had no direction of straw use.</p> <p>R18's Kardex printed 8/20/24, directed staff to provide R18 with a cup and lid for hot beverage safety. R18's Kardex lacked indication R18 should not use straws.</p> <p>R18's care plan revised 4/3/24, indicated R18 had a nutritional problem related to inadequate oral intake. Interventions include to use adaptive cup with covers and indicated R18 declined adaptive silverware. R18's care plan lacked indication R18 should not use straws.</p> <p>An observation on 8/20/24 12:123 p.m., nursing assistant (NA)-A entered R18's room with their lunch tray. The lunch tray was set down on the bedside table and a pillow was placed behind R18's shoulders/back to help R18 sit up a bit more. NA-A obtained a chair and assisted R18 with lunch. R18 had red juice and water in a handled cup with a spout lid. NA-A placed a straw in both cups and assisted R18 with drinking out of them. At 12:30 p.m., NA-A cleaned up R18 and removed the lunch tray leaving the remainder of the juice and water on R18's tray in front of them. At 12:58 p.m., R18 reached and drank some water through the cup and straw.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 8/20/24 at 1:55 p.m., NA-A stated R18 was incontinent and required total assistance with repositioning and ADLs. NA-A verified R18 had been using straws had been told in report straws were ok to use.</p> <p>When interviewed on 8/20/24 at 2:20 p.m., licensed practical nurse (LPN)-B stated R18 required assistance and encouragement with meals and was able to use straws with beverages. LPN-B acknowledged R18's diet order instructing no straws and stated they had not been aware of that before. LPN-B thought it was an old order that had not been changed.</p> <p>When interviewed on 8/21/24 at 2:19 p.m., registered nurse (RN)-A was not sure why R18's diet order indicated no straws and verified it was initially written in 2021. Upon review, RN-A stated R18 had discharged from the hospital with that order and had initially signed onto hospice. Speech therapy had not seen her as initially ordered due to hospice. R18 had graduated from hospice in 12/2021 due to improvements and had not been seen by speech since then. RN-A stated staff should be following the order for no straws or following up with the provider.</p> <p>When interviewed on 8/21/24 at 2:22 p.m., speech therapist (ST) verified has not evaluated R18 since return from the hospital. ST stated there could be a re-evaluation for use of straws or a risk-benefits signed to ok the use, but otherwise the order for use of straws should be followed.</p> <p>When interviewed on 8/22/24 at 2:19 p.m., the Director of Nursing (DON) expected staff to be following instructions on the dietary card. If there were questions or conflicting information about what was needed, staff should be asking and get the information clarified.</p> <p>A facility policy titled Diet Orders revised 4/19/224, directed staff to monthly, the diet roster should be compared to the provider orders to ensure compliance with the provider order.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586</p> <p>Based on observation, interview, and document review the facility failed to assess 1 of 1 residents (R12) reviewed for bedrails.</p> <p>R4's significant change Minimum Data Set (MDS) dated [DATE], indicated, intact cognition and diagnoses of displaced bicondylar fracture of right tibia, atrial fibrillation, and chronic kidney disease (CKD). It further indicated R4 required assistance from staff with most activities of daily living (ADL) and mobility.</p> <p>R4's physician's order dated 5/7/24, indicated okay to install assist bar. Follow manufacturers recommendations and specifications to promote independence with bed mobility. Risk vs benefit have been reviewed and consent form signed. No directions specified for order.</p> <p>R4's Informed Consent for Bed Rails, was signed by R4 on 5/13/24.</p> <p>During observation and interview on 8/19/24 7:59 a.m., R4 was sitting in her room, registered nurse (RN)-D verified the bilateral side rails on her bed and stated all the residents have them for positioning. RN-D stated the resident needs to have a consent signed but wasn't sure about whether or not they need to have an assessment.</p> <p>During interview on 8/22/24 at 7:35 a.m., registered nurse (RN)-E stated in order for a resident to have bed rails they need a doctor's order, consent, and a safety assessment. RN-E was not not sure who was responsible for completing the assessment.</p> <p>During interview on 8/22/24 at 9:15 a.m., nurse manager registered nurse (RN)-A stated residents need to have a doctor's order, signed consent, assessment, care planned, and a desire to have them. That is important for the possibility of restraint RN-A also verified R12 did not have an assessment and it was important for the resident to be assessed for the possibility of it being a restraint.</p> <p>During interview on 8/22/24 at 2:19 p.m., the director of nursing (DON) stated in order for a resident to use side rails they would need to have a desire to want them up/on, a consent form would need to be filled out, ensure there was a benefit to the resident to have them installed, and a safety assessment.</p> <p>The facility's policy regarding bed rails dated 9/8/23, indicated: bed rail/side rail/assist bar usage will occur only when:</p> <p>a. Medical necessity is supported by resident assessment and data collection documentation allowing resident to assist or be independent with bed mobility and/or transfer.</p> <p>b. When the total bed environment i.e. bed frame, mattress bed rail/assist bar device and overlays) have been inspected and verified to be free of entrapment risk.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. Informed consent is obtained from resident and/or responsible party and then documented in the medical record, may use the Informed Consent for</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>46885</p> <p>Based on interview and document review, the consulting pharmacist (CP) failed to address an appropriate indication for an antidepressant for 1 of 1 resident (R212) reviewed for psychotropic medications.</p> <p>Findings include:</p> <p>R212's comprehensive Minimum Data Set (MDS) in progress dated 8/15/24, indicated intact cognition, had coronary artery disease and hypertension (high blood pressure), acute myocardial infarction (heart attack), presence of an aortocoronary bypass graft, and had an encounter for surgical after care following surgery on the circulatory system. Further, R212 did not have little interest or pleasure in doing things, and did not feel down, depressed, or hopeless.</p> <p>R212's physician orders dated 8/9/24, indicated R212 took bupropion (an antidepressant) HCL ER (extended release) 150 mg by mouth two times a day for status post CABG (coronary artery bypass grafting).</p> <p>R212's Medical Diagnosis form dated 8/21/24 at 1:39 p.m., indicated the following diagnoses: encounter for surgical aftercare following surgery on the circulatory system, presence of aortocoronary bypass graft, non-ST elevation myocardial infarction (heart attack), atherosclerotic heart disease of native coronary artery, essential hypertension. The form lacked information R212 had depression.</p> <p>R212's hospital discharge summary dated 8/9/24, indicated R212 was to continue taking the following medication: bupropion 150 mg take 1 tablet twice a day for S/P CABG.</p> <p>R212's nurse practitioner (NP) progress note dated 8/15/24, indicated R212 took bupropion 150 mg twice daily, further R212's mood and affect was normal.</p> <p>R212's pharmacist medication review dated 8/15/24, indicated the following recommendations:</p> <p>R212 was prescribed quetiapine (an antipsychotic) 25 mg tablet daily at bedtime with an associated diagnosis of S/P CABG listed with it in the electronic medical record (EMR). Per CMS (Centers for Medicare and Medicaid Services) guidelines, this may not be a sufficient diagnosis to warrant the use of an antipsychotic. Antipsychotics should be reserved for situations where psychosis/delusions are present or situations where the patient poses an acute risk for harm to self or other. Please clarify the diagnosis for the Seroquel and update the EMR-if an adequate diagnosis is not present, consider tapering off of this medication. The pharmacist medication review lacked information regarding bupropion and an associated diagnosis of S/P CABG.</p> <p>During interview on 8/21/24 at 11:09 a.m., the consulting pharmacist (CP)-A stated bupropion was an antidepressant medication and a diagnosis of CABG was not a correct indication for bupropion and stated he wrote the recommendation for the quetiapine and stated the rationale would hold true for any psychotropic R212 was on.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 8/22/24 at 12:00 p.m., the director of nursing (DON) stated CP-A completed pharmacy reviews and sends them over, they are printed and reviews for the physician are provided to the medical director and if a review is for nursing, the review is provided to the nurses. DON further stated the pharmacist should have identified the incorrect indication on the first initial review for the bupropion and further, it was important to have the correct diagnosis to track R212's depressive mood.</p> <p>A policy, Psychotropic Medications Rehab/Skilled dated 12/6/23, indicated the resident will be free from any chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used without adequate indications for its use.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586</p> <p>Based on interview and document review the facility failed to ensure residents that were prescribed psychotropic medications were monitored for side effects, for 1 of 5 residents (R50) and failed to develop and implement non-pharmacological interventions for 1 of 5 residents (R110) reviewed for unnecessary medications.</p> <p>Findings include</p> <p>R110's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, diagnosis of Bipolar disorder, was independent to requiring supervision with activities of daily living (ADL) and received an antipsychotic on a routine basis.</p> <p>R110's care area assessment (CAA) for psychotropic drug use dated 8/7/24, indicated: R110 received an antipsychotic, antidepressant, and hypnotic medication. Resident for drug induced Parkinsonism, multiple falls, chronic back pain, and myelofibrosis for diagnosis of bipolar disorder. Resident appears to tolerate medication without adverse reaction. Nursing staff observe for mood and behavior, and potential adverse reaction with administration of medication.</p> <p>R110's physician's orders dated 8/1/24, indicated olanzapine oral tablet 15 milligrams (mg). Give 15 mg by mouth at bedtime for psychosis.</p> <p>R110's care plan dated 8/5/24, indicated R110 was on antipsychotic medication therapy related to bipolar and psychosis. It further contained the following interventions:</p> <ul style="list-style-type: none"> -R110 will be free of any discomfort or adverse side effects from antipsychotic medication use through the review date. -monitor resident condition based on clinical practice guidelines or clinical standards of practice related to use of (olanzapine). -consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate. -WARNINGS #1: Refer to boxed warnings in the orders or eMAR, or medication reference of choice <p>R110's care plan lacked any indication of non-pharmacological interventions.</p> <p>During interview on 8/22/24 at 9:15 a.m., nurse manager registered nurse (RN)-A stated staff should have developed and implemented non-pharmacological interventions on the care plan for residents who received an antipsychotic medication and verified R110's care plan lacked individualized non pharmacological interventions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 8/22/24 at 2:19 p.m. the director of nursing (DON) stated non pharmacologic interventions should be developed, implemented, monitored, care planned and documented for residents who receive an antipsychotic medication.</p> <p>46885</p> <p>R50's admission Minimum Data Set, dated dated [DATE], indicated severe cognitive impairment, did not have little interest or pleasure in doing things, and did not feel down, depressed, or hopeless, did not have physical, verbal, or other behaviors, had diagnoses of dementia and depression and took an antipsychotic and antidepressant medication.</p> <p>R50's care area assessment (CAA) worksheet dated 7/16/24, indicated R50 took duloxetine (an antidepressant) and aripiprazole (an antipsychotic) for depression and psychotropic drug use would be addressed in the care plan in order to minimize risks.</p> <p>R50's physician orders indicated the following orders:</p> <p>7/4/24, aripiprazole 20 milligrams (MG) by mouth once daily.</p> <p>7/4/24, duloxetine 30 mg by mouth every evening, and 60 mg by mouth every morning. R50's orders lacked any monitoring for side effects of duloxetine and aripiprazole.</p> <p>R50's care plan was reviewed and lacked information R50 had depression and further lacked any monitoring for side effects of duloxetine and aripiprazole.</p> <p>R50's Pharmacist Medication Review form dated 8/15/24, indicated R50 was on Aspirin 325 mg daily indicated Aspirin was indicated for the prevention and or treatment of a wide variety of cardiovascular condition, and there was general consensus across guidelines that when used for primary or secondary cardiovascular prevention, lower doses of Aspirin have similar efficacy to higher doses, but carry less risk for significant bleeds. Please consider lowering this patient's Aspirin to 81 mg daily. The review lacked information for monitoring for side effects of aripiprazole or duloxetine.</p> <p>R50's Pharmacist Consultant review dated 7/19/24 indicated R50 was on aripiprazole 20 mg daily, please order monthly orthostatic blood pressure monitoring.</p> <p>R50's Pharmacist Consultant review dated 7/4/24 indicated no potential clinically significant medication issues identified at this time.</p> <p>R50's registered nurse (RN) and social worker (SW) mood symptoms 30 day look back report printed 8/21/24, lacked any documentation of whether or not mood symptoms were exhibited.</p> <p>R50's Mood symptoms 30 day look back report printed 8/21/24, also lacked documentation whether or not mood symptoms were exhibited.</p> <p>R50's Behavior 30 day look back task form printed 8/21/24, lacked documentation whether or not R50 had any behaviors.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 8/21/24 at 11:15 a.m., the consulting pharmacist (CP)-A stated antidepressant side effect monitoring included monitoring for central nervous system changes, whether a resident starts falling, weight loss and weight gain and further stated specific manifestations can take a few weeks and did not see any specific orders for R50.</p> <p>During interview on 8/21/24 at 12:03 p.m., registered nurse (RN)-C stated if a resident was on a psychotropic medication, it was added to the careplan and any monitoring for side effects showed up in the medication administration records. RN-C viewed the orders and stated R50 should have monitoring because R50 was on aripiprazole and duloxetine and verified the orders lacked monitoring and further RN-C viewed R50's care planned and verified R50 did not have a care plan related to psychotropics. RN-C also viewed R50's discontinued orders and verified there were no orders for monitoring and stated it should be there and would have to follow up with the director of nursing.</p> <p>During interview on 8/21/24 at 11:49 a.m., nursing assistant (NA)-B stated she would have to ask the nurse to see what kind of medications a resident was on and could also look in the Kardex to see if there were any behaviors to watch for.</p> <p>During interview on 8/22/24 at 12:13 p.m., the director of nursing (DON) stated monitoring was completed weekly and should be part of the documentation and whether the medications are effective and stated monitoring was supposed to be in the nursing orders and checked the care plan and verified the care plan lacked information R50 was on aripiprazole and duloxetine or had any kind of monitoring in place.</p> <p>A policy, Psychotropic Medications Rehab/Skilled dated 12/6/23, indicated each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose including duplicate drug therapy, for excessive duration, without adequate monitoring, without adequate indications for its use, in the presence of adverse consequences that indicate the dose should be reduced or discontinued, any combination of the reasons above. Before administration of non-emergency psychotropic medications, the following must be completed: documentation in the electronic medical record (EMR) observations of mood, symptoms or behaviors that cause the resident distress and or endanger the resident or others and response to interventions used. The behavior committee and or care plan team will ensure the care plan is updated. This update will reflect non pharmacological interventions to be used. Throughout the administration of the psychotropic medications, the following must be completed; mood and behavior documentation must continue in order to monitor the effect the medication has on behavior. Monitor for side effects of the medication. If a side effect occurs or worsening of a known side effect is noted, the nurse will make a note in the record and notify the physician and family and legal representative of this change in condition. Non-pharmacological interventions are recommended before medication interventions. Attempts should be documented in the resident care record.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>42586</p> <p>Based on interview and document review the facility failed to ensure the Quality Assessment and Assurance (QAA)/Quality Assurance Process improvement (QAPI) committee was effective in implementing appropriate action plans to correct quality deficiencies identified in previous surveys related to weekly skin assessments which resulted in deficiencies identified during this survey. This deficient practice had the potential to affect all 61 residents in the facility.</p> <p>The Certification and Survey Provider Enhanced Reports (Casper)-3 assessment (data was converted to quality measures (QM) to evaluate nursing homes performance) dated 8/11/24, identified the following previous deficiency by month and year.</p> <p>-F686 Treatment/services to prevent/heal pressure ulcers at a scope and severity level of a D.</p> <p>See also F686 Based on interview and document review, the facility failed to ensure weekly skin assessments were completed for 2 of 3 (R3, R12) residents reviewed for pressure ulcer risk.</p> <p>Monthly QAPI meeting minutes dated 5/26/23, indicated performance improvement plan (PIP) for high risk pressure ulcers-current percentage for the month of April 2023 was 9.1%. State was 7.3% and national norm is 9.0%. Continue to see some long term care residents with chronic reoccurring areas that are non-compliant with repositioning/off loading to reduce pressure ulcer risk. Risks and benefits are explained to the residents and documented in point click care (computer program). Although the QAPI minutes provided documentation the facility was working on addressing high risk pressure ulcers, it lacked indication it was addressing missing weekly skin assessments.</p> <p>During interview on 8/22/24 at 3:00 p.m., the director of nursing (DON), stated the facility was working on addressing high risk pressure ulcers by looking at the clinically complex nature of people who were already admitting with pressure ulcers, some of which had wound vacs and trying to promote healing. They also really wanted involvement with a medical doctor, so the facility decided to get Vohera (name of a wound care company) to come in once a week. The DON also stated they address pressure ulcers in their weekly interdisciplinary team (IDT) meetings and how important documentation was. The main issue was getting the nurse to complete the documentation and not put it to the wayside. It is so important to do a skin assessment. We have provided education and the nurse manager RN-A has recently made time in the nurses schedule that is dedicated to completing skin assessments.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885</p> <p>Based on observation, interview, and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was donned (applied) for 2 of 2 residents (R42, R18) who were on enhanced barrier precautions (EBP), and 2 of 2 residents (R55, R111) on transmission based precautions, and failed to ensure appropriate hand hygiene and glove use for 3 of 3 residents (R42, R7, R18). Additionally, the facility failed to take appropriate steps to diagnose and manage a COVID-19 outbreak in accordance with Centers for Disease Control (CDC) guidance.</p> <p>Findings include:</p> <p>According to the Centers for Disease Control (CDC) Infection Control Guidance: SARS-CoV-2 updated [DATE], Infection Control Guidance: SARS-CoV-2 COVID-19 CDC under the heading, Nursing Homes, indicated the approach to an outbreak investigation could involve either contact tracing (an attempt to find all contacts of a confirmed case in order to test or monitor for infection) or a broad-based approach; however, a broad-based such as unit, floor, or other specific areas of the facility approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected units or facility-wide every 3 to 7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered.</p> <p>R55:</p> <p>R55's admission Minimum Data Set (MDS) dated [DATE], indicated R55 had intact cognition.</p> <p>R55's Admission Record form dated [DATE], indicated R55 had COVID-19 on [DATE].</p> <p>R55's care plan dated [DATE], indicated R55 tested positive for COVID-19 on [DATE]. Interventions included observing for symptoms, monitoring breath sounds, rate rhythm, and use of any accessory muscles, when possible all services brought to resident in room such as rehabilitation, activities, and dining, droplet and contact precautions wear gowns, gloves, N95 masks (if available), and eye protection when changing contaminated linens.</p> <p>R55's care plan dated [DATE], indicated R55 had COVID-19 on [DATE], and interventions included encouraging R55 to wear a mask while staff in the room and when going outside of the room, encourage social distancing as appropriate per MDH (Minnesota Department of Health) and CDC (Centers for Disease Control) recommendations, provide a private room and use airborne/contact precautions, all cares provided in the private room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R55's Order Summary Report dated [DATE], indicated R55 had an order dated [DATE], for airborne and contact precautions for 10 days and all cares and therapies were completed in room.</p> <p>R55's nursing progress notes dated [DATE], indicated R55 was on isolation droplet precautions and all services were being rendered in R55's room.</p> <p>R5:</p> <p>R5's admission MDS dated [DATE], indicated intact cognition.</p> <p>R5's Admission Record form dated [DATE], indicated R5 had COVID-19 on [DATE].</p> <p>R5's care plan dated [DATE], indicated R5 had COVID-19 on [DATE]. Interventions included to encourage R5 to wear a mask while staff in the room and when going outside of the room. Encourage social distancing as appropriate per MDH/CDC recommendations, provide private room and use contact/airborne precautions. All cares provided in a private room.</p> <p>R5's Order Summary report dated [DATE], indicated R5 had an order dated [DATE], ok for airborne and contact precautions. Patient can be placed in a single room and all meals, care, and therapy provided in the room for 10 days every shift for COVID-19 for 10 days.</p> <p>R5's progress notes dated [DATE], indicated R5 's respiratory infection was potentially a result of COVID-19 and R5 was on isolation droplet precautions and all services rendered in R5's room.</p> <p>R111:</p> <p>R111's admission MDS dated [DATE], indicated intact cognition.</p> <p>R111's Admission Record form dated [DATE], indicated R111 had COVID-19 on [DATE].</p> <p>R111's care plan dated [DATE], indicated R111 tested positive for COVID-19 on [DATE]. Interventions included to encourage R111 to wear a mask while staff were in the room and when going outside of the room, provide a private room and use airborne/contact precautions, all cares provided in a private room.</p> <p>R111's Order Summary report dated [DATE], indicated R111 had an order dated [DATE], ok for airborne and contact precautions. Patient can be placed in a single room and all cares, meals, and therapy provided in room for 10 days every shift for COVID-19 for 10 days.</p> <p>R111's progress notes dated [DATE] at 7:26 p.m., indicated R111's respiratory infection was potentially a result of COVID-19, was on droplet precautions, and all services rendered were completed in R111's room.</p> <p>R215:</p> <p>R215's admission MDS dated [DATE], indicated intact cognition.</p> <p>R215's Admission Record form dated [DATE], indicated R215 had COVID-19 on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R215's care plan dated [DATE], indicated R215 tested positive for COVID-19 on [DATE]. Interventions included, encourage R215 to wear a mask while staff were in the room and when going outside of the room, provide a private room and use airborne/contact precautions, all cares provided in a private room.</p> <p>R215's Order Summary Report dated [DATE], indicated the following orders:</p> <p>[DATE], complete SARS-COV-2 testing on all residents ongoing per CDC.</p> <p>[DATE], notify the provider about any symptoms of hypoxia every shift for COVID.</p> <p>[DATE], ok for airborne and contact precautions, single room isolation for all cares for 10 days every shift for COVID.</p> <p>R215's progress notes dated [DATE] at 2:23 p.m., indicated R215's family member was updated on the recent COVID positive result.</p> <p>R215's progress notes dated [DATE] at 7:46 p.m., indicated R215's respiratory infection is potentially a result of COVID-19 and was on isolation airborne precautions and contact isolation precautions.</p> <p>R4:</p> <p>R4's admission MDS dated [DATE], indicated intact cognition.</p> <p>R4's Admission Record form dated [DATE], lacked information R4 had COVID-19.</p> <p>R4's care plan dated [DATE], indicated R4 tested positive for COVID-19 on [DATE] and was on strict isolation in a private room with airborne and contact precautions. Interventions indicated contact precautions: wear gowns and masks when changing contaminated linens, provide a private room and use contact precautions. The care plan lacked interventions for using an N95 mask.</p> <p>R4's Order summary Report form dated [DATE], indicated the following order:</p> <p>[DATE], complete SARS CoV 2 testing on all residents ongoing per CDC.</p> <p>[DATE], airborne and contact precautions patient can be placed in a single room and all cares, meals and therapy is provided in room every shift for COVID-19 for 10 days.</p> <p>R4's progress notes dated [DATE] at 10:59 p.m., indicated R4's infection was potentially a result of COVID-19 and was on airborne and contact isolation precautions.</p> <p>Facility team sheets dated [DATE], were divided into 4 teams: team 1, team 2, team 3 and team 4. Team 3 included the following residents: R55, R5, R111, R215, and R4 who all tested positive for COVID-19. Additionally, R110, R43, R12, and R214, were on Team 3.</p> <p>Facility POC COVID-19 Test forms were reviewed and identified the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R55 tested positive for COVID-19 on [DATE].</p> <p>R5 tested negative for COVID-19 on [DATE], and [DATE]. Additionally, another test dated [DATE], indicated R5 tested positive for COVID-19.</p> <p>R111 tested positive for COVID-19 on [DATE], no previous tests were located.</p> <p>R215 tested negative for COVID-19 on [DATE], and [DATE].</p> <p>R4 tested negative for COVID-19 on [DATE], and tested positive for COVID-19 on [DATE].</p> <p>R110 tested negative for COVID-19 on [DATE], and negative for COVID-19 on [DATE].</p> <p>R43 tested negative for COVID-19 on [DATE], no previous tests were located.</p> <p>R12 tested negative for COVID-19 on [DATE], and on [DATE].</p> <p>R214 tested negative for COVID-19 on [DATE].</p> <p>Facility form, Monthly Report of Resident Infections in Location dated [DATE], indicated the following:</p> <p>R55 had COVID-19 on [DATE], and a productive cough with nasal drainage,, and congestion started on [DATE].</p> <p>R5 had COVID-19 on [DATE], and had symptoms of a productive cough, nasal drainage with congestion on [DATE].</p> <p>R111 had COVID-19 on [DATE] and symptoms of a non productive cough started on [DATE].</p> <p>R215 had COVID-19 on [DATE], and symptoms started on [DATE].</p> <p>R4 had COVID-19 on [DATE], and symptoms started on [DATE].</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on [DATE] at 7:53 a.m., the infection preventionist (IP) stated she worked as the IP every Wednesday, Thursday, and Friday. IP stated if an employee showed up to work with symptoms of a reportable communicable disease, they were tested with a rapid COVID-19 test and if they had signs or symptoms, would be sent home. IP stated they had 5 residents who tested positive for COVID-19, and all were on team 3. IP further stated all staff should wear a surgical mask on the unit and a designated nurse and nursing assistant (NA) would care for those residents with full PPE to include an N95 mask, gloves, gown, and a face shield. IP stated the N95 masks should fit securely to the face with no other mask located inside the N95 and regular glasses were not sufficient because they were not protective. IP further stated a couple staff were sick, one staff person had not worked at the facility and the other one was sent home as soon as they found out the staff person was COVID-19 positive. IP further stated they completed contact tracing and stated she was just finishing up on that on [DATE]. IP stated with contact tracing, they look at someone in contact with a person at 6 feet or less for 15 minutes or more and test on day 1, then 48 hours later, and an additional 48 hours after that. IP stated COVID-19 first started when R55's family member was positive for COVID-19, did not mask, and did not tell staff their positive status. IP further stated the 2nd person was R5 on [DATE], then R111 on [DATE], and then R215 on [DATE], and last, R4 tested positive on [DATE]. IP stated when not working, the director of nursing (DON) or nurse manager will test residents if they have signs and symptoms and will start transmission-based precautions and if a resident had symptoms and tested negative, they would require two negative tests 48 hours apart. IP stated they had four additional residents on team 3 and did not know whether they were tested and verified the residents were R110, R43, R12, and R214 and stated she planned to follow up on those residents [DATE]. IP stated it was a situation where testing should be done on group three if staff were wearing PPE and a designated nurse and NA looked after the individuals. Further, IP stated hand hygiene occurred prior to entering a room and completing a task such as activities of daily living, take off the gloves, wash hands and don new gloves. Not sanitizing hands can bring bacteria and spread infection if donning gloves without performing hygiene. IP stated residents on enhanced barrier precautions (EBP) had incisions, ulcers, catheters, and signage was placed outside the resident's door and a cart was placed in the hallway. If a resident had COVID-19, they were not on EBP, but were on airborne and droplet precautions. IP expected staff to don a gown and gloves for EBP and the signage instructed staff what the high-risk areas were including dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care, central lines, urinary catheters, feeding tube, tracheostomy, wound care, and any skin opening requiring a dressing according to the CDC.</p> <p>During interview on [DATE] at 10:55 a.m., registered nurse (RN)-B stated she tested at home and did not have signs or symptoms of COVID-19 and if there was a COVID-19 outbreak, they tested on day 1, 3, and 5 and further stated with this outbreak, all staff would be tested but did not know whether residents would also be tested and stated if they have signs and symptoms, they were tested right away.</p> <p>During interview on [DATE] at 10:57 a.m., nursing assistant (NA)-B stated she tested for COVID-19 this morning and had been testing the last 3 days and was without signs or symptoms. NA-B stated she heard that morning the facility would be testing everyone on the unit and staff due to everyone walking through the floors.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on [DATE] at 11:02 a.m., RN-F walked down the hall with four tests for COVID AG cards and stated they were all negative tests for R12, R43, R110, and R214 and stated these residents were on team 3 in the middle of other residents who had COVID. RN-F further stated they test residents and staff, and the test results were placed in a folder.</p> <p>During interview on [DATE] at 2:19 p.m., the director of nursing (DON) stated COVID-19 testing was completed on residents who were symptomatic or had an exposure and they watched for signs and symptoms. DON further stated employees with close contact were also tested and stated the first case of COVID-19 was on [DATE], then [DATE], [DATE], [DATE], and [DATE]. DON further stated they tested the other four residents on team 3 who were negative but did not think they completed testing promptly enough. The DON further stated she expected staff to wear an N95, gloves and a gown along with face shields and staff could not wear regular glasses as an eye protectant to prevent the spread of COVID-19. DON further stated the N95 had to be fitted to the face without a surgical mask underneath. Further, the DON stated she expected staff complete hand hygiene before and after glove use. The DON stated signs for EBP went up on admission and expected gloves and gowns to be worn for any close contact.</p> <p>A COVID-19 Confirmed Case Checklist dated [DATE], indicated when a case of COVID-19 has been suspected or confirmed in the location, the resident is confined to their room, airborne and contact transmission-based precautions are initiated, employees are assigned to care for the positive resident, source control is implemented on affected units, look back two days from start of symptoms or positive test, whichever was sooner, to identify all residents, staff and visitors as able who had close contact or higher risk exposure with this resident, initiate outbreak testing via contact tracing or broad-based testing. Test all employees and residents determined to be close contacts/higher risk exposures on day 1, 3, and 5 and contact trace any additional identified positives. If unable to conduct contact tracing, move to broad based testing of all employees and residents on a unit/hall or facility on day 1, day 3, and day 5. If the outbreak becomes uncontained, move to testing of all employees and residents every 3 to 7 days until no new cases of COVID-19 are identified for 14 days.</p> <p>42586</p> <p>R55's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition and a diagnoses of COVID-19.</p> <p>R55 required partial/moderate assistance with ADL's and mobility.</p> <p>R55's physician's order dated [DATE], indicated droplet precautions x 10 days. All cares and therapies in room, every shift for 10 days.</p> <p>R55's care plan dated [DATE], indicated R55 has respiratory infection: tested Positive for COVID on [DATE]. It further indicated the following interventions:</p> <ul style="list-style-type: none"> -observe for symptoms, e.g., cough, changes in functional ability or activity tolerance, O2 saturations, etc. -monitor/document breath sounds, document rate, rhythm, and the use of any accessory muscles. -when possible, all services brought to resident in room (e.g. rehabilitation, activities, dining, etc.). <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-DROPLET and CONTACT PRECAUTIONS: Wear gowns, gloves, N95 masks (if available), and eye protection when changing contaminated linens. Bag linens and close bag tightly before taking to laundry.</p> <p>-encourage/assist resident to perform hand hygiene</p> <p>-monitor/document/report new or worsening signs/symptoms of COVID-19 fever of 100.0 or greater, chills, shortness of breath, difficulty breathing, new or change in cough, sore throat, new loss of taste or smell, new sputum production, congestion, runny nose (rhinorrhea), fatigue, muscle or body aches, headache, nausea or vomiting, or diarrhea.</p> <p>-keep door closed for isolation</p> <p>-provide private room if available.</p> <p>R111 (TA) admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnosis of COVID-19. R111 required substantial assistance with mobility, lower extremity impairment on one side, used a walker and a wheelchair, and had a catheter.</p> <p>R111's physician' orders dated [DATE], indicated ok for droplet precautions. Patient can be placed in a single room and all cares, meals, and therapy provided in room for 10 days, every shift for COVID-19 for 10 days.</p> <p>R111's care plan dated [DATE], indicated has infection testing positive for COVID on [DATE] and is in strict isolation droplet and contact precautions. It further included the following interventions:</p> <p>-monitor/document/report to health care provider s/s of delirium: Changes in behavior, altered mental status, wide variation in cognitive function throughout the day, communication decline, disorientation, periods of lethargy, restlessness and agitation, altered sleep cycle.</p> <p>-when possible, all services brought to resident in room (e.g. rehabilitation, activities, dining, etc.).</p> <p>-CONTACT PRECAUTIONS: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry.</p> <p>-educate resident/family regarding preventive measures to contain the infection.</p> <p>-provide private room and use contact precautions.</p> <p>During observation on [DATE] at 5:35 p.m., there was a sign on the outside of R111's and R55's door which indicated: Airborne Precautions everyone must: clean their hands, including before entering and when leaving the room. Put on an N95 or higher level respirator before room entry. Remove respirator after exiting the room and closing the door. Door to room must remain closed. Nursing assistant (NA)-F entered R111's room wearing 2 surgical masks, gown, and personal eye glasses. NA-F then exited the room (after having removed the gown) and donned another gown, and entered R55's room, set her meal tray down, removed her gown, and exited the room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on [DATE] at 5:40 p.m. NA-F verified knowing the residents in rooms R111 and R55 were on airborne precautions due to testing positive for COVID-19 and was supposed to be wearing an N95 but was unable too stating I can't breathe with an N95 mask on so I wear 2 surgical masks instead. R55 was also supposed to wear goggles/eye protection but was unable to find any stating sometimes we're short of that.</p> <p>During observation and interview on [DATE] at 5:47 p.m., RN-G went into R111's room wearing an N95 with a surgical mask underneath it, a gown, and no eye protection. RN-G stated they weren't wearing eye protection because they were just giving the resident his pills, but should have been. Staff should wear eye protection every time they go into a residents room who are on airborne precautions. All staff have been fitted for an N95 and shouldn't be wearing a surgical mask underneath it.</p> <p>During observation and interview on [DATE] at 12:28 p.m., nursing assistant (NA)-G entered R111's room wearing an N95 with a surgical mask underneath, a gown, and no eye protection. NA-G stated they had been fitted for N95's and didn't know if it was acceptable to wear a surgical mask underneath it. NA-G further stated he didn't wear eye protection because he wasn't performing cares and was only bringing the resident his meal tray.</p> <p>During interview on [DATE] at 12:35 p.m., registered nurse (RN)-E stated when entering a residents room who is on airborne precautions, staff are required to wear a gown, gloves, N95, and face shield. Anyone who enters the room for any reason needs to wear personal protective equipment (PPE) even if they are not performing cares. All staff have been fitted for an N95 and should not be wearing a surgical mask underneath it. RN-E also verified rooms [ROOM NUMBERS] were airborne precaution rooms due to residents testing positive for COVID-19.</p> <p>During interview on [DATE] at 9:15 a.m., nurse manager registered nurse (RN)-A stated any staff entering a resident's room who is on airborne precautions was required to wear an N95, face shield, gown, and gloves, even if they weren't performing cares. Staff must wear eye protection and not their own personal eye glasses and they must wear the N95 they have been fitted for. A surgical mask should not be worn underneath. If staff are not wearing the appropriate PPE they are putting themselves and other residents at risk of transmission and could expose them to getting COVID-19.</p> <p>44647</p> <p>R18</p> <p>R18's quarterly Minimum Data Set (MDS) dated [DATE], indicated R18 had cognitive impairment and diagnoses of heart disease, Alzheimer's Disease, and anxiety disorder. R18's MDS also indicated R18 had pressure injury and was dependent on staff for mobility.</p> <p>R18's care plan revised [DATE], indicated R18 required EBP related to open wounds. Interventions including ensuring staff wore gown and glove when performing high contact care activities including transferring repositioning, and personal hygiene.</p> <p>R18's Kardex printed [DATE], directed staff to don gown and gloves when performing high contact care activities such as dressing, providing hygiene, repositioning, changing linens and personal cares.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An observation on [DATE] at 1:13 p.m., R18 was seated in a wheelchair in her room with lunch in front of her. Outside her door to the left was a EBP sign and directed staff to gown and glove when providing high contact care.</p> <p>An observation on [DATE] at 2:03 p.m., nursing assistant- (A) and licensed practical nurse (LPN)-A entered to assist R18 back to bed. Outside of R20's room to the left of the door was an EBP sign that directed staff to gown and glove when providing high contact care. Hand hygiene was performed upon entrance and gloves were donned however NA-A and LPN-A had not donned a gown. R18 was lifted with the Hoyer lift and placed in bed. NA-A removed R18's slippers. NA-A unfastened R18's brief and tucked it down. NA-A provided cares from the front before LPN-A assisted to turn R18 to the side. NA-A removed R18's wet brief. R18's bottom had blanchable redness and skin was intact. NA-A cleaned R18 from the back side and removed gloves. Without performing hand hygiene, R18 applied new gloves and applied barrier cream before placing a clean brief and assisted R18 to roll on their back. LPN-A pulled the brief through and secured. NA-A then removed gloves and without performing hand hygiene donned new gloves. NA-A adjusted R18 to tilt to their right side and covered up. NA-A then removed gloves and tied garbage. Hand hygiene was performed, and NA-A and LPN-A exited the room.</p> <p>An interview on [DATE] at 2:17 p.m., NA-B verified the EBP sign to the side of R18's door. R18 stated they had not noticed the sign and should have worn a gown when providing cares to R18. NA-B also verified they had not performed hand hygiene in-between glove exchanges and was supposed to.</p> <p>When interviewed on [DATE] at 7:536 a.m., the IP expected staff to perform hand hygiene upon when exchanging gloves during cares. This was important to minimize the risk spreading bacteria and risk of infection for the residents.</p> <p>When interviewed on [DATE] at 2:19 p.m., the Director of Nursing (DON) expected staff to perform hand hygiene before and after glove removal. EBP signs were place for residents with any open area, foley, feeding tube, and wounds. Staff were expected to follow EBP when providing close contact cares such as transferring and personal or hygiene cares.</p> <p>48299</p> <p>R7</p> <p>R7's quarterly Minimum Data Set (MDS) dated [DATE], indicated R7 was cognitively intact and had diagnoses of heart failure (heart does not pump blood as well as it should), hypertension (high blood pressure), and chronic obstructive pulmonary disease (lung disease which blocks airflow and makes it difficult to breath). R7 required supervision or touching assistance for toileting hygiene and transfers.</p> <p>During observation on [DATE] at 2:00 p.m., nursing assistant (NA)-C placed transfer belt around R7, applied gloves, and assisted R7 to stand from her wheelchair in the bathroom. R7 sat on the toilet and was incontinent of bowel, and NA-C removed and threw away the incontinent product. NA-C unlocked R7's wheelchair and backed out of bathroom, grabbed a clean incontinent product, returned to bathroom, and moved wheelchair closer to resident and locked wheelchair. R7 stood up from the toilet, and NA-C wiped R7's, applied clean incontinent product, pulled up R7's underwear and pants and fixed R7's shirt. NA-C assisted R7 into wheelchair grabbing the transfer belt, removed the transfer belt, wiped the toilet seat, then removed gloves and washed hands.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on [DATE] at 2:12 p.m., NA-C stated R7 required limited assistance for activities of daily living (ADLs). NA-C stated staff performed hand hygiene between assisting residents and between changes gloves. NA-C stated glove change and hand hygiene should be completed after dirty tasks and before clean tasks, and verified they did not change gloves during toileting and incontinence cares. NA-C stated glove changes and hand hygiene were important to prevent infection.</p> <p>During interview on [DATE] at 7:53 a.m., the infection preventionist (IP) expected staff to take gloves off and perform hand hygiene after assisting with ADLs, such as incontinence cares, and before touching clean items. This was important to minimize the risk of spreading bacteria and risk of infection for the residents.</p> <p>During interview on [DATE] at 2:19 p.m., the Director of Nursing (DON) expected staff to perform hand hygiene before and after glove removal.</p> <p>49893</p> <p>R42</p> <p>R42's face sheet printed [DATE], indicated diagnoses of pneumonia, heart failure, and diabetes</p> <p>R42's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R42 had moderate cognitive impairment, no upper or lower extremity impairment, uses a wheelchair, dependent on staff for toileting hygiene, bathing, lower body dressing, and substantial assist for personal hygiene and bed mobility. R42 was frequently incontinent of urine and always incontinent of bowel. R42 has moisture associated skin damage (MASD)</p> <p>R42's careplan indicated R42 required enhanced barrier precautions related to open wounds. Interventions included wearing gown and gloves when performing high contact are activities including dressing, bathing, transferring, providing hygiene, changing linens, repositioning, and/or wound care.</p> <p>R42's Kardex printed [DATE] directed staff to don gown and gloves when performing high contact care activities such as dressing, transferring, bathing, hygiene, changing linens, repositioning, and wound care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During observation on [DATE] at 1:39 p.m., a sign on was noted on the wall outside R42's door indicated EBP with instructions to don gown and gloves for high contact care. Nursing assistant (NA)-A entered R42's room with shower chair and NA-C entered room with mechanical lift. Both NA-A and NA-C arrived wearing gloves however did not don gowns. NA-D removed blankets and pillows from R42's bed. NA-C removed R42's pants. NA-C reached across R42 and assisted with rolling him to his right side. NA-C's scrub top was observed touching R42's bed. NA-D removed R42's incontinence product and placed mechanical lift sling under R42. NA-C and NA-D then rolled R42 to his left side exposing a bandage to R42's buttocks. Center of bandage was noted to be saturated with drainage. NA-C disposed of incontinence product in a garbage bag. Without removing gloves or performing hand hygiene, NA-C and NA-D assisted with transferring R42 from bed to the shower chair. Stool was noted on draw sheet on R42's bed. NA-C and NA-D then removed gloves with NA-D washing hands in bathroom. NA-C left room. NA-D brought R42 to the shower room. NA-D applied gloves however did not don gown. NA-D washed, rinsed, and towel dried R42. With the same gloves, NA-D wrapped R42 in sheet and blanket. NA-D then gathered shower linens placing them in bin. NA-D removed gloves and, without performing hand hygiene, took R42 back to his room. NA-D donned gloves however no gown. NA-D removed soiled linens from R42's bed and applied clean linens wearing the same gloves. NA-C entered room wearing gloves and no gown. NA-D removed gloves and donned new gloves without hand hygiene. R42 was transferred from shower chair to bed. NA-D and NA-C assisted with applying incontinence product and dressing R42. NA-C removed gloves and left the room. NA-D tidied room, removed gloves, opened window shades and put on new gloves. No hand hygiene was performed. NA-D then took bag of dirty linen and shower chair back to shower room.</p> <p>During interview on [DATE] at 2:52 p.m., NA-D confirmed signage outside R42's room indicating EBP. NA-D stated gowns and gloves are to be worn for cares, transferring, dressing changes, and bathing. NA-D also stated hand hygiene should be performed before and after wearing gloves or when hands are dirty. NA-D confirmed they should have worn a gown when transferring and bathing R42 and should have performed hand hygiene after removing gloves.</p> <p>During interview on [DATE] at 2:52 p.m., NA-C stated residents with wounds and catheters require EBP. Gown and gloves are required depending on level of contact, such as changing or helping residents getting dressed. NA-C stated they did not don a gown because they did not notice a sign outside R42's door.</p> <p>During interview on [DATE] at 10:51 a.m., RN-A stated they would expect staff to don gloves and gown for direct care, clothing management, showering, and all other high contact cares for residents on EBP and confirmed staff should have worn gowns when assisting R42. RN-A stated she would expect staff to sanitize hands before donning and after doffing gloves.</p> <p>During interview on [DATE] at 1:04 p.m., the director of nursing stated residents are evaluated for EBP on admission. All residents with incisions, wounds, and medical devices inserted in body are placed on EBP. She would expect staff to wear gowns for close contact with residents and remove gowns before leaving the room. The director of nursing confirmed she would have expected NA-D and NA-C to wear gown and gloves when performing cares and bathing for R42. The director of nursing further confirmed she would expect staff to perform hand hygiene between glove change.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Maplewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A policy tilted Multidrug-Resistant Organisms, MRSA VRE CRE and ESBL, All service Lines-Enterprise dated [DATE] indicated All resident's with any of the following: wounds and/or indwelling medical devices (e. g., central line, urinary catheter, feeding tube, tracheostomy/ventilator: regardless of MDRO colonization status are to be placed on EBP. Personal protective equipment (PPE) are used for high-contact resident care activitie [TRUNCATED]</p>		