STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. Building B. Wing	08/28/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure unpasteurized eggs were fully cooked and prepared in a manner to prevent/decrease the risk of foodborne illness. This had the potential to affect up to 40 residents residing at the facility who ate undercooked eggs weekly. Findings include: A facility invoice for the periods of 8/7/25, 8/14/25, and 8/21/2025 indicated the facility received 115 dozen whole large white eggs on each order. The invoices did not include an indication that these eggs were pasteurized (a process used to eliminate bacteria and disease-producing microorganisms in foods, such as dairy). A Shopping Cart record dated 8/27/25 at 2:00 p.m., indicated the facility had a case of medium shelled pasteurized eggs in their shopping cart. A facility invoice indicated these shelled pasteurized eggs had been delivered on 8/28/25.During an observation and interview on 8/25/25 at 11:41 a.m., an unopened 15 dozen box of eggs was observed in a double-door refrigerator. There were no markings on the box to indicate the eggs had been pasteurized. The dietary manager (DM) stated these eggs were used to make poached eggs and fried eggs every Thursday for the residents' breakfast. The DM confirmed these poached and fried eggs would be undercooked and have runny yolks, but this was the only time eggs were served in this manner. The DM confirmed she was unable to find labeling on the box indicating the eggs were pasteurized, but would find the order invoice, as she thought they were pasteurized. On 8/26/25 at 1:55 p.m., the DM stated she found the order invoices and the eggs in the refrigerator observed on 8/25/25 were not pasteurized. The DM stated the poached and/or fried eggs facility staff had been serving on Thursdays had been unpasteurized for at least the past month but was unable to determine the exact length of time unpasteurized eggs were being served. The DM stated she would complete education with her staff to ensure pasteurized eggs were used when eggs were cooked with a runny yolk and would change the order with her supplier to ensure the facility had pasteurized whole eggs on hand. During an interview on 8/27/25 at 9:38 a.m., cook (C)-A confirmed that she helped cook eggs for breakfast service regularly. C-A stated she knew the difference between pasteurized and unpasteurized eggs, but had just not noticed the eggs were unpasteurized until it was brought up this week. C-A stated kitchen staff had been using the unpasteurized eggs to cook poached eggs with running yolks. C-A stated the fried eggs sometimes had runny yolks, but not always. C-A stated approximately 40 residents consumed the poached or fried eggs on Thursdays. During an interview on 8/28/25 at 10:10 a.m., the director of food and nutrition (DFN), a registered dietician, stated she would expect staff to utilize pasteurized eggs when cooking in a manner that the yolk was still runny because of the risk of foodborne illness associated with undercooked unpasteurized eggs. The DFN stated unpasteurized eggs had been served as poached eggs, and it was possible the yolks of these were running or undercooked, but the facility residents had not had any foodborne illness associated with these eggs. The facility's Food Handling- Food and Nutrition policy dated 6/27/25, indicated hard-cooked eggs were safe for consumption, and runny eggs should not be served unless they were prepared from pasteurized eggs.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and document review, the facility failed to ensure insulin pens were stored in a manner to prevent cross-contamination in 3 of 3 medication carts on the transitional care unit (TCU). This deficient practice had the potential to affect all residents who required insulin administration via an insulin pen who resided in the facility.Findings include: During observation and interview on 8/27/25 at 10:38 a.m., registered nurse (RN)-E was at the one of three medication carts on TCU preparing medication administration. RN-E removed an insulin pen from a plastic cup in a red tote in the bottom of the medication drawer. The plastic cup contained other insulin pens prescribed for multiple residents, no barrier noted between the pens. RN-E stated this was the way the insulin pens had always been stored after opening and stated they were all in one cup, touching each other without a barrier between. During observation and interview on 8/27/25 at 12:22 p.m., RN-F opened remaining two of three medication carts on TCU. RN-F stated there were several different resident's insulin pens together without a barrier separating the pens. RN-F stated not being aware the insulin pens should not be stored together and touching other resident's pens and that this was how they had been stored since she started working at this facility. During interview on 8/27/25, RN-A stated was not aware of an issue with insulin pens being stored together. RN-A thought they should be stored apart from other types of medication. During interview on 8/27/25 at 1:31 p.m., Infection Preventionist (IP) stated each resident's insulin pens should be separated from other resident pens. IP stated separating the pens with a barrier would prevent possible cross contamination. During interview on 8/27/25 at 1:36 p.m., director of nursing (DON) stated they were not aware insulin pens needed to be stored separated by resident or with a barrier between each resident's pen, but thought it was a good idea. Facility policy Medication: Insulin Administration, Insulin Pens, Insulin Pumps dated 9/5/24, indicated, Contamination of these devices [insulin pens] can occur externally [even in the absence of visible blood].resulting in the potential for transmission of blood borne pathogens when used for multiple people. Facility policy Medications: Acquisition Receiving Dispensing and Storage dated 3/4/25, indicated, All medication will be stored in accordance with manufacturers' recommendations. Refer to [facility] Insulin Administration. policy.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure resident specific advanced directive orders were accurately reflected throughout the medical record for 1 of 1 resident (R75) investigated for advanced directives (AD).R75's face sheet (undated) indicated diagnoses of wedge compression fracture of the T11-T12 vertebra, congestive heart failure (CHF), and chronic kidney disease (CKD). R75's Brief interview of Mental Status (BIMS) assessment dated [DATE], indicated intact cognition. R75's Functional Ability assessment dated [DATE], indicated R75 required assistance from staff with most activities of daily living (ADL) and mobility. R75's physician's orders indicated the following:-[DATE] advanced directive DNR-[DATE] attempt CPR R75's face sheet banner in Point Click Care (computer program) indicated code status (Advance Directive) of Do Not Resuscitate (DNR) and to attempt Cardiopulmonary Resuscitation (CPR). R75's Physician's Order for Life Sustaining Treatment (POLST) dated [DATE], indicated to attempt CPR. During interview on [DATE] at 3:18 p.m. R75 stated he wanted a good faith attempt at life saving measures, if he was found to be unresponsive/emergency situation. He further stated his AD should not be DNR. During interview on [DATE] at 8:57 a.m., registered nurse (RN)-C stated the first place they would look for code status (if a resident became unresponsive) would be on the POLST but it can also be found on the face sheet banner. RN-C verified they would have given him CPR because that is what the POLST indicated, however they further verified the face sheet banner in PCC indicated both CPR and DNR and stated that was confusing and could lead to error. During interview on [DATE] at 9:52 a.m. licensed practical nurse (LPN)-A stated if a resident was found unresponsive, the first place they would look for code status would depend on their location. If they were on their computer, they would look on the face sheet banner in PCC. If they were closer to the POLST book, they would look at the POLST. There are lots of places you could look. LPN-A further stated if there was a discrepancy, they would use the code status on the face sheet banner in PCC because that is the most accurate. During interview on [DATE] at 10:23 a.m., RN-D stated if a resident was found unresponsive, the first place they would look for code status was on the face sheet banner in PCC because that is the most accurate. During a follow up interview on [DATE] at 1:08 p.m., the surveyor showed LPN-A R75's face sheet banner in PCC which indicated both CPR and DNR and asked what they would do in that situation. LPN-A stated they would look at the actual orders and if they contained both orders, then they would get clarification from the nurse practitioner (NP). LPN-A stated she would not give direction to other staff regarding what action to take while she waited for direction from the NP. During interview on [DATE] at 9:56 a.m., the director of nursing (DON) stated if a resident was found unresponsive, the first-place nurses should look for the code status would depend on the nurse's location. If their computer was up and running, they should look on the face sheet banner in PCC, if they are closer to the desk they should look in the POLST book. After reviewing R75's face sheet banner in PC, DON stated as R75 had both DNR and CPR listed, she would look down in the orders and if there still was a discrepancy she would look in On-Base (computer program) to look at the POLST. The DON also stated this could cause a delay in R75 receiving CPR. The facility policy regarding advanced directives dated [DATE], was received but didn't address the first place to look for a resident's code status.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure range of motion (ROM) was completed according to therapy recommendations for 1 of 1 resident (R4) reviewed for ROM. Findings include: R4's admission Minimum Data Set (MDS) dated [DATE], indicated R4's cognition was not assessed. R4 had impairment of upper and lower extremities on both sides and was dependent on staff for all mobility, transfers, and all activities of daily living (ADL), R4's MDS indicated R4 had received physical therapy (PT) and occupational therapy (OT) and zero minutes of restorative nursing to include active and passive range of motion (PROM). R4 did not exhibit rejection of care behaviors and had diagnoses including cerebral infarction (stroke), cognitive communication deficit, and quadriplegia (paralysis affecting all limbs). R4's care plan dated 7/30/25, indicated R4 had a need for restorative intervention due to limited mobility and required passive ROM to bilateral upper and lower extremities and neck with restorative nursing. R4's PT treatment encounter note dated 8/13/25, indicated, Patient appears at max functional potential at this time and recommendation for transition from PT to RNP [restorative nursing program] for [NAME] [lower extremity] ROM program and caregiver training completed with both RNP staff and family for successful program with goal to prevent contractures and maintain joint integrity. R4's PT Discharge summary dated [DATE], indicated, Caregiver training completed with daughter/spouse and RNP staff for carryover program on unit for B [bilateral] [NAME] PROM. R4's therapy communication to nursing staff form dated 7/29, indicated, FMP [functional maintenance program] for PROM for [NAME] [lower extremity] exercises at least 3x/wk [three times a week]. An additional therapy communication form dated 7/29/25, indicated, OT FMP: RN [restorative nurse] Please perform PROM for neck & Bilateral UE's [upper extremities] at least 3x/week. R4's nursing care sheet dated 8/25/25, lacked evidence R4 required ROM. R4's 30-day lookback task report printed 8/27/25, indicated ROM on bilateral upper and lower extremities and neck was completed one time, refused twice and not applicable twice. During interview on 8/25/25 at 3:40 p.m., family member (FM)-A stated R4 was supposed to be receiving PROM exercises from staff but that was not happening. R4 indicated, by shaking head side-to-side, staff was not completing PROM. During interview on 8/26/25 on 2:13 p.m., nursing assistant (NA)-A stated residents residing on TCU (transitional care unit) did not typically receive restorative nursing since they were generally still receiving therapy. NA-A stated on occasion the long term care restorative nurse aide (RNA) would ambulate or exercise with TCU residents. NA-A was not aware of any resident on TCU currently receiving restorative nursing. During interview on 8/26/25 at 2:30 p.m., director of PT and OT (DPTOT) stated therapy would notify nursing of restorative nursing recommendations using a therapy to nursing communication form. DPTOT further stated they would expect RNP to be completed as recommended. During observation on 8/27/25 at 7:24 a.m., NA-A and NA-B entered R4's room. NA-A and NA-B placed pillows under each side of R4 and under each arm. R4's head of bed was raised. NA-A offered R4 a blanket to cover her, R4 declined. PROM was not performed or offered. During interview on 8/27/25 at 8:22 a.m., registered nurse (RN)-E stated if therapy recommended RNP for someone on TCU, which was rare, it would be on a communication form and then entered into the chart as an order to be displayed and charted in the TAR (treatment administration record). During interview on 8/27/25 at 8:28 a.m., physical therapy aide (PTA) stated therapy used the communication form to notify nursing of recommended RNP. PTA further stated they completed a communication form for R4 recommending PROM to be completed since PT was discontinued. PTA stated they would expect nursing to follow through on recommendations and for R4 to receive PROM exercises at least three times a week. During interview on 8/27/25 at 10:36 a.m., NA-A stated R4 was not on a RNP and PROM was not being done. NA-A stated OT was working on positioning in R4's wheelchair and nursing focused on repositioning R4 frequently to prevent skin (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breakdown. During follow up interview on 8/27/25 at 10:47 a.m., RN-E stated if the task was not on the TAR, it was not being done. RN-E stated R4 was not receiving any restorative nursing. During interview on 8/27/25 at 11:48 a.m., RN-B stated they were not aware of anyone currently on RNP on TCU. RN-B stated nursing would have received a communication form from nursing for RNP and the task would be entered as an order to display on the TAR for nursing to complete. RN-B was not aware of a RNP for R4. During interview on 8/27/25 at 12:25 p.m., RN-A stated would receive a communication form from therapy with recommendations would be received. Recommendations would be entered on a RNA task sheet in PCC (point click care) to be documented when completed. RN-A further stated the intervention would be added to the resident's care plan. RN-A stated a RNA was scheduled five days a week so all RNPs could be completed. During interview on 8/27/25 at 1:34 p.m., director of nursing (DON) stated PROM was usually performed by RNA as part of a RNP when the resident was on LTC, and when recommended should be completed while on TCU as well. DON stated R4 should have received PROM as part of a RNP. Facility policy Restorative Nursing Care Implementation and Screening dated 11/27/24, indicated, The goal of restorative nursing care is to attain and maintain the maximum possible independence and/or prevent rapid declines through their interventions for each resident. The policy further indicated, The restorative nurse had the overall responsibility and accountability for the restorative program. In the event the location does not have a designated restorative nurse, the responsibility and accountability remain with the director of nursing services. The policy indicated RNA and other designated and trained staff will provide care under the supervision of the restorative nurse, therapists, or DON. Facility policy Restorative Nursing Documentation dated 7/7/25, indicated, recommendations from therapy for a RNP will be added to a resident's care plan and entered into PCC for documentation.