

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 08/13/2026
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)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure resident assessments were accurate for 1 of 1 resident (R61) reviewed for dental. Findings include: R61's annual Minimum Data Set (MDS) dated [DATE], indicated R61 was cognitively intact and required setup or clean-up assistance with oral hygiene. R61's MDS did not identify any oral or dental concerns. Obvious or likely cavity or broken natural teeth was not checked 0-Not checked [No]. R61's diagnoses included diabetes and chronic pain syndrome. R61's care plan revised 7/27/26, indicated R61 had activities of daily living (ADLs) self-care performance and that R61 had her own teeth, some with crowns. R61's HealthDrive (HD- an outside source for medical and dental support for long term care facilities) note dated 12/30/25, indicated R61 had ten missing teeth and three fractured teeth. R61's HD note dated 5/26/26, indicated R61 was scheduled for dental appointment, but declined due to not feeling well. R61's electronic medical record (EMR) lacked evidence of any other dental appointments. R61's quarterly MDS nursing assessment dated [DATE], indicated, Obvious or likely cavity or broken natural teeth. Not checked [No]. During observation and interview on 8/11/26 at 8:19 a.m., R61 had several teeth missing. R61 had obvious missing teeth on her upper front gumline and several scattered along her lower gumline. R61 stated she had a lot of missing teeth and at least one broken tooth on the upper and back right side. R61 stated she was hoping to get a plate for the upper front and to have the broken tooth fixed or extracted. During interview on 8/13/26 at 8:50 a.m., licensed practical nurse (LPN)-A stated quarterly or annual nursing assessments were often completed by nursing staff. LPN-A stated the MD nurse (MDS-RN) would place a nursing order to display on the resident's treatment administration record (TAR) when the assessment was due. LPN-A stated the assessment should be a face to face assessment. During interview on 8/13/26 at 8:58 a.m., MDS-RN stated she entered a nursing order for the assessments per the required schedule and would expect nursing to complete the assessments accurately. MDS-RN stated she relied on the data from the nursing assessments and other documentation to code the MDS and an inaccurate assessment could cause the MDS to be coded inaccurately. MDS-RN stated an inaccurate assessment could also affect the residents care plan and ultimately the care they received. During interview on 8/13/26 at 3:59 p.m., director of nursing (DON) stated would expect nursing assessments to accurately reflect the resident's status. Facility policy Dental and Oral Care, Dental Health Assessment, Dental Services dated 3/3/26, indicated the purpose of dental assessments was to ensure early identification and evaluation of any dental/oral health problems for treatment by a dentist or other professional to begin as early as necessary.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure quarterly care conferences were provided or offered for 1 of 1 resident (R61) reviewed for care planning. Findings include: R61's quarterly Minimum Data Set (MDS) dated [DATE], indicated R61 was cognitively intact and did not exhibit rejection of care behavior. R61's diagnosis included major depressive disorder, anxiety, chronic pain, and diabetes. R61's progress note dated 5/21/25, indicated a conference occurred without R61 or a resident representative for R61 were in attendance. Invited resident, expressed again does not want to participate in care conferences. Informed resident that facility still has to inform/invite for each care conference even if refuses. Resident verbalized understanding. R61's electronic medical record (EMR) lacked evidence any other care conference was offered, provided, or refused after 5/21/25. During interview on 8/11/26 at 8:09 a.m., R61 stated she did not always know what the plan was and could not remember attending or being offered a care conference in a long time. During interview on 8/12/26 at 2:45 p.m., social worker (SW)-A stated care conferences were documented in the EMR as a care conference note type in progress notes. SW-A verified and stated there were no care conferences documented in R61's EMR since May of 2025. SW-A stated it did not make sense that R61 would not have had a care conference since then and they should be completed quarterly. Further, R61 was due for a care conference in March and June of 2026, and that family member (FM)-A would have been invited to attend. During interview on 8/12/26 at 3:02 p.m., FM-A stated she had not been invited to or attended a care conference in over a year and did not really know what was going on with R61's care. FM-A further stated she felt like she was not being kept in the loop and that it was very frustrating. During follow up interview on 8/12/26 at 3:17 p.m., SW-A stated she thought R61 had been appropriately offered care conferences but had refused them. During interview on 8/13/26 at 3:59 p.m., director of nursing (DON) stated would expect quarterly care conferences would be completed and offered and if the resident declined to participate, the EMR would have evidence of the refusal. DON further stated care conferences were important to keep the resident and/or family members updated on the resident's plan of care. Facility policy Comprehensive Care Plan and Care Conferences dated 12/29/25, indicated, Social worker or designated employee will. Invite residents and their representative [with resident's permission] at least two weeks in advance of the care conference. If resident and/or representative is not invited to the care conference, an explanation must be included in the medial record.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure the resident's fall interventions were in place for 1 of 1 (R9) residents reviewed for falls. Findings include: R9's Quarterly Minimum Data Set (MDS), dated [DATE], indicated diagnoses of dementia and end-stage renal disease (ESRD) required dialysis. R9 had intact cognition but was at risk for falls that required supervision with activities of daily living (ADL's), transfers and used a walker for ambulation. R9's falls assessment, dated 6/15/25, indicated she was a fall risk due to ESRD required dialysis, impulsive behavior, and impaired mobility. R9's nursing and provider orders dated 3/18/25, indicated that R9 was to be up with nursing assistance, reminded to use the call light and wait for staff assistance, and monitored through frequent safety checks each shift. R9's Safe Event Incident report dated 6/4/26, R9 was found sitting on the floor between her drawer and walker. R9 had bleeding from a forehead injury and a skin tear to her jaw and was transferred to the hospital, where she received stitches. the root cause was R9 lost her balance when she walked to her drawer to close it. The intervention following this fall included placement of skid strips next to the bed to prevent falls. R9's care plan, dated 7/8/26, indicated a self-care performance deficit related to actual falls, weakness, and impaired mobility. R9 required assistance from one staff member, a walker, and a gait belt for ambulation. R9 also required assistance from one staff member with transfers, bathing, dressing, personal hygiene, and toilet use. Additionally, R9 had dementia with decreased safety awareness and demonstrated impulsive self-transfers and self-ambulation. Interventions included restorative rehabilitation; education for R9 and family regarding fall prevention and factors that could cause falls; use of assistive devices; placement of skid strips next to the bed to prevent falls; and frequent monitoring of R9 for safety. Additionally, R9 was at risk for falls, the interventions were to provide assistance of one staff with walker during transfers and ambulation. She also had a wheelchair she could use independently. It instructed to remind R9 to use call light, wait for staff assistance, and have staff perform safety checks each shift. During an observation on 8/12/26 at 8:28 a.m., R9's room door was open. R9 was standing in the bathroom. Her walker and wheelchair were located in her room near her bed and not within arms reach. R9 independently ambulated to her wheelchair and sat down. At 8:30 a.m., R9 stood and walked to her walker. She independently ambulated with the walker to the bathroom and brushed her teeth. At 8:32 a.m., an unidentified staff member walked past R9's room but did not enter room. At 8:34 a.m., R9 was observed ambulating in room her room using her walker without staff present. At the same time, an unidentified staff member walked past R9's room, glanced into the room, and continued walking down the hallway. During an observation on 8/13/26 at 7:57 a.m., R9 was seated in a wheelchair in her room. R9 stood, ambulated to a recliner, and self-transferred without staff assistance or her walker which was located by the wall adjacent to the wheelchair. The call light was on recliner arm, and non-skid shoes on. At 8:01 a.m., R9 was observed ambulating in her room from the recliner to the wheelchair without a using her call light, walker or staff present. During an interview on 8/11/26 at 3:24 p.m., R9 that she walked in room by herself, self-transferred and used the bathroom independently. R9 stated that the facility did not have control over her, that she did not need to follow instructions, and that she was going to do what she wanted. During an interview on 8/12/26 at 9:17 a.m., NA-A stated that when a resident fell, staff were to notify the nurse, obtain vital signs, and remain with the resident to assist the nurse. NA-A stated that resident care was provided according to the care plan and written care sheets. During an (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 8/12/26 at 10:13 a.m., registered nurse (RN)-D stated that when a resident fell, staff were to call for assistance and assess the resident for injuries. If the resident hit their head, neurological checks were to be performed, and the resident was monitored for a change in condition. RN-D stated that staff used a mechanical lift to elevate a resident from the floor when the assessment indicated it was appropriate. Otherwise, the resident was sent to the hospital for further treatment. RN-D stated that staff utilized the care plan and Kardex to provide the necessary care. RN-D further stated that it was important to follow provider orders for resident safety and to ensure appropriate care and progress. RN-D stated that orders were specific to each resident's care and that following the care plan was important for resident safety and autonomy. During an interview on 8/13/26 at 8:02 a.m., NA-B confirmed that R9 transferred independently and that he had observed R9 ambulating in her room without a walker or staff assistance. NA-B stated that he was unaware R9 was a fall risk. He also verified R9 used the bathroom and was walking independently. NA-B stated that he referred to the care plan when providing care to residents. During an interview on 8/13/26 at 8:14 a.m., RN-E stated that R9 was not supposed to self-transfer. RN-E stated that multiple-colored signs were posted on the walls of R9's room instructing her to call, not fall, wait for assistance, and remember to use call light. RN-E stated that R9 had memory loss and required frequent education regarding safety and redirection. RN-E stated that the care plan indicated that R9 was to have skid strips placed. RN-E verified the skid strips were not present on the floor despite the care plan indicating that they were to be used to prevent falls. During an interview on 8/13/26 at 3:25 p.m., the director of nursing (DON) stated that the expectations for staff when a resident had a fall was to assess the resident for injuries and call 911 when necessary. If the fall was not serious, the resident was assessed and moved using a mechanical lift. The provider, family, and supervisor were to be notified. The fall was documented as a safe-event incident report and reviewed during the interdisciplinary team (IDT) weekly leadership meeting. The DON stated that it was important to follow orders to provide current and appropriate care for each resident. The DON stated that the care plan was designed to provide instructions for the individual resident and was updated by the DON and nurse managers. The facility's policy titled Fall Prevention and Management, reviewed on 6/2/26, instructed staff to promote resident well-being by developing and implementing a fall prevention and management program, identifying risk factors, and implementing interventions before a fall occurred. The policy also instructed staff to provide prompt treatment after a fall occurred. A nurse was required to observe the resident and perform a full-body examination to determine whether an injury occurred, continue to monitor the resident's condition, and update the plan as needed. Staff were required to complete a safe-event incident report and fall-scene huddle worksheet and communicate that a fall had occurred to the provider, family, supervisor, during stand-up meetings, at change of shift, and through the 24-hour report.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure respiratory equipment was properly maintained for 1 of 1 resident (R31) reviewed for respiratory care. Findings include: R31's quarterly Minimum Data Set (MDS) dated [DATE], indicated R31 was cognitively intact and required oxygen therapy. R31's diagnoses included multiple sclerosis and hypoxemia (low blood oxygen level). R31's care plan dated 5/19/26, indicated R31 had shortness of breath (SOB) related to diagnoses and required oxygen therapy. R31's August 2026, treatment administration record (TAR) indicated, Nursing Order: Change oxygen supplies, including oxygen bubbler [container filled with water in-line with oxygen to provide humidification], and tubing. Date and initial every night shift every Wed for routine exchange and maintenance. During observation on 8/10/26 at 5:44 p.m., R31 was in bed, receiving oxygen through a nasal cannula. R31's oxygen PM bubbler was dated 6/4/26. During interview and observation on 8/10/26 at 5:54 p.m., registered nurse (RN)-A stated the oxygen tubing and bubbler was supposed to be changed weekly and confirmed R31's bubbler was dated 6/4/26 and stated it should have been changed since then. RN-A stated if oxygen supplies were not maintained properly, the chance of contracting respiratory infection increased. RN-A stated R31 required oxygen therapy for SOB and was not aware that she experienced any recent respiratory infections. During interview on 8/13/26 at 1:35 p.m., RN-B, who was also the staff educator, expected nurses to follow provider orders as written. During interview on 8/13/26 at 3:59 p.m., director of nursing (DON) stated would expect nurses to follow orders as written and that R31's bubbler should have been changed weekly. Facility policy Oxygen Administration, Safety, Mask Types, dated 7/16/26, indicated all oxygen equipment should be clean, safe, and functional and all disposable pieces changed weekly.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure that the required personal protective equipment (PPE) was used for 1 of 1 resident (R73) reviewed for Contact Precautions. Findings include: R73's MDS dated [DATE], identified R73 was admitted on [DATE], was cognitively intact, and diagnoses that included congestive heart failure, heart disease, kidney problems, and recurrent Clostridioides difficile (C. difficile, a highly contagious infection spread by contact). R73's care plan dated 8/4/26, identified R73 required Contact Precautions and a private room due to C. difficile infection. R73's nursing progress note dated 8/10/26 at 9:53 p.m., identified R73 had active C. difficile infection. R73's nursing order dated 8/11/26, indicated R73 could be removed from isolation precautions. R73's nursing progress note dated 8/12/26 at 8:37 a.m., identified Contact Precautions were discontinued on 8/11/26, with 8/10/26 identified as the last full day of isolation. During observation on 8/10/26 at 6:02 p.m., Contact Precautions signage was posted outside R73's room and indicated all people entering the room were required to wear a gown and gloves. PPE supplies were located across the hall from R73's room. During an interview on 8/10/26 at 6:06 p.m., R73 stated staff did not always wear a gown when entering the room but usually wore gloves. R73 stated caregivers wore a gown and gloves when providing direct care. During an observation on 8/10/26 at 6:10 p.m., RN-C entered R73's room with medications without wearing a gown or gloves and touched the bedside table and interior surface of the room door. During an interview on 8/13/26 at 9:00 a.m., RN-C stated staff determine what required PPE is used by reviewing signage outside residents' rooms. RN-C verified that R73 was on Contact Precautions for C. difficile infection, as indicated by signage posted on R73's door. RN-C stated staff wear a gown and gloves when providing direct care to residents on Contact Precautions but wear only gloves when delivering medications or entering resident's rooms for non-care-related tasks. RN-C confirmed she did not wear a gown or gloves when entering R73's room because she was only delivering medications. During an interview on 8/14/26 at 4:40 p.m., the interim director of nursing (DON) confirmed staff were expected to wear a gown and gloves when entering R73's room while Contact Precautions were in place. The facility's Standard, Enhanced Barrier, and Transmission-Based Precautions policy, revised 4/30/26, identified Contact Precautions were required for residents with infections that posed an increased risk for contact transmission. The policy directed staff to put on a gown and gloves before contact with the resident or the resident's environment and to remove PPE before leaving the room.		