STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Specialty Care Community	3815 West Broadway Avenue Robbinsdale, MN 55422

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to promote dignity while providing care for 1 of 3 residents (R1) reviewed who required assistance with activities of daily living. Findings include:R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 admitted to the facility on [DATE], was severely cognitively impaired, required staff assistance for transfers, and had diagnoses that included dementia. During an interview on 5/13/26 at 8:32 a.m., R1's family member (FM)-A stated she had a video of staff yelling at R1 when R1 asked for help. The FM-A stated R1 reported being upset after staff yelled at her. The FM-A did not understand why staff would yell at a resident with the diagnosis of dementia. The FM-A stated it was upsetting to see the video and further stated she wanted R1 cared for by people who wanted to help R1. The staff in the video did not seem like they wanted to help. During an interview on 5/13/26 at 4:04 p.m., the nursing assistant (NA)-C stated staff should not call residents grandma or momma because it was not professional, and it was not allowed at the facility. Staff should instead call residents by their preferred name and should treat residents kindly.During an interview on 5/13/26 at 4:17 p.m., the registered nurse (RN)-B stated staff were supposed to be respectful and call resident's by their preferred name, not momma or grandma. During an observation with the administrator and the director of nursing (DON) on 5/14/26 at 11:00 a.m., review of a video from the camera in R1's room dated 4/3/26 at 7:54 p.m., revealed two staff talking to R1. The DON and administrator identified the staff in the video as NA-E and NA-E. NA-E told R1 she was asking for help for no reason, stated R1 was cutting up and it was the last time staff would be in the room. NA-E then addressed R1, grandma. The DON stated staff should treat residents with respect. Also during the observation and review of a video from the camera in R1's room dated 4/3/26 at 8:14 p.m., revealed two staff, the NA-A and the NA-B, transferred R1 with a Stand Aid (device used to assist resident from sitting to standing position and from standing to sitting position). The DON and administrator acknowledged it was NA-A in the video and the NA-A who was standing in front of R1 during the transfer who encouraged R1 to sit. When R1 sat the NA-A stated, There you go momma. During an interview on 5/14/26 at 1:46 p.m., the NA-B stated she had not worked with R1, even though she was identified by the administrator and DON in the video dated 4/3/26 at 8:14 p.m. During an interview on 5/14/26 at 1:48 p.m., the DON stated staff was expected to be respectful towards residents, the preferred name could be added to the care plan. Staff were not allowed to call residents grandma or momma because that was not respectful. The Resident Dignity policy dated 12/18/25 indicated staff would care for residents in a manner that maintained or enhanced each resident's dignity and respect and treat residents with respect and address each resident by their preferred name.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Specialty Care Community	3815 West Broadway Avenue Robbinsdale, MN 55422

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and document review the facility failed to implement care plan interventions for 1 of 3 residents (R1) when staff transferred R1 with pivot transfers (technique for moving a resident from one position to another. While standing, resident moves their feet to turn toward the new surface) instead of with the Stand Aid (non-motorized device to assist a person to a standing position), as indicated in the care plan. Findings include:R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 admitted to the facility on [DATE], was severely cognitively impaired, required staff assistance for transfers, and had diagnoses that included fractures, dementia and multiple traumas. R1's care plan dated 3/23/26 indicated R1 required assistance of one staff for toileting and transferred with a Stand Aid.During an interview on 5/13/26 at 8:32 a.m., R1's family member (FM)-A stated she was concerned about the way staff transferred R1. R1 was transferred by two people moving R1 instead of the machine [stand aid] staff were supposed to use. FM-A stated she had videos of R1's transfer from the toilet to the wheelchair, and from the wheelchair to the bed, indicating staff did not use the stand aid for transfers. During an interview on 5/13/26 at 3:56 p.m., the nursing assistant (NA)-D stated she did not recall how R1 was supposed to transfer, but staff would refer to the therapy book on the counter of the nurses' station to know how each resident was supposed to transfer. During an interview on 5/13/26 at 4:04 p.m., NA-C stated she was supposed to use the Stand Aid to transfer R1. The NA-C stated she always used the Stand Aid with R1 and did not transfer R1 without it because R1 could fall using a pivot transfer. During an interview on 5/13/26 at 4:44 p.m., the administrator stated R1's care plan indicated R1 required use of the stand aid and staff assistance for transfers.During an interview on 5/13/26 at 4:49 p.m., the registered nurse (RN)-A stated she did not remember R1. The RN-A stated a resident's care plan directed staff in how to transfer a resident safely and it was unsafe to transfer a resident with a pivot transfer instead of a Stand Aid if the therapy department directed staff to use a Stand Aid. During an interview on 5/14/26 at 10:13 a.m., the licensed practical nurse (LPN)-A stated when a resident's care plan indicated transfer with a Stand Aid, staff should transfer with a Stand Aid. R1 required the Stand Aid because she could not bear weight on both legs. During an observation with the physical therapy assistant (PTA)-A on 5/14/26 at 10:40 a.m., upon review of the video footage from the camera in R1's room, dated 4/4/26 at 8:17 p.m., revealed two staff pivot transferred R1 from the toilet to her wheelchair. The two staff did not use the Stand Aid. The PTA-A reviewed a second video dated 4/4/26 at 8:18 p.m., that revealed the same two staff transferred R1 from the wheelchair to R1's bed with a two-person pivot transfer instead of a Stand Aid. During an interview on 5/14/26 at 10:40 a.m., the PTA-A stated R1 was supposed to be transferred with a Stand Aid, and not with a two-person pivot transfer. The transfers on the video footage was not completed according to R1's care plan. Further, the PTA-A stated the therapy department kept a book at the nurses' station which gave direction how each resident was supposed to be transferred. The PTA-A stated R1 was supposed to transfer with the Stand Aid. During an observation with the administrator and clinical director (CD)-A on 5/14/26 at 11:00 a.m., upon review of the video dated 4/4/26 at 8:17 p.m., revealed two staff pivot-transferred R1 from the toilet to her wheelchair instead of using a Stand Aid. The administrator and CD-A reviewed a second video dated 4/4/26 at 8:18 p.m., that revealed the same two staff transferred R1 from the wheelchair to R1's bed with a two-person pivot transfer instead of a Stand Aid. During an interview on 5/14/26 at 11:00 a.m., the CD-A stated he did not see a Stand Aid in the videos. If the care plan indicated staff were supposed to use a Stand Aid, they should have used a Stand Aid for safety to ensure the resident did not fall. During an interview on 5/14/26 at 1:07 p.m., the director of nursing (DON) and administrator identified the staff from the two videos who transferred R1 from the toilet to the wheelchair and the wheelchair to the bed without a Stand Aid as NA-C and NA-D.During (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Specialty Care Community	3815 West Broadway Avenue Robbinsdale, MN 55422

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 5/14/26 at 1:34 p.m., the NA-A acknowledged she worked on 4/4/26 and assisted another staff to transfer R1 with a gait belt from the toilet to the wheelchair. The NA-A was aware R1's care plan indicated use the Stand Aid. The NA-A stated the Stand Aid was not used because R1 wanted to transfer with the gait belt instead. The NA-A stated she preferred to transfer residents with a pivot transfer and gait belt instead of using a Stand Aid, but sometimes R1 was able to stand and sometimes could not. R1 was not always able to remember to stand because R1 had dementia. The NA-A stated if the resident did not want to follow the care plan and use the Stand Aid, the NAs could talk to the nurse and use a two-person assist for transfers instead of following the care plan. During an interview on 5/14/26 at 1:49 p.m., NA-B stated she did not remember working with R1. To know how a resident was supposed to transfer, staff referred to the therapy book at the nurses' station or asked another staff who knew the resident. During an interview on 5/14/26 at 1:48 p.m., the DON stated R1 was supposed to transfer with a Stand Aid and one staff per R1's care plan. Therapy staff determined the residents' ability to transfer and put each resident's transfer status in the therapy book at the nurses' station. If a resident did not choose to follow the care plan the NA would ask a nurse for help to educate the resident about the risks and benefits of not following the care plan for safe transfers. When a resident has dementia, staff should attempt to perform the transfer according to the care plan for safety to prevent falls. The Care Plan for Therapy and Rehab policy dated 12/1/25 indicated the care plan used to provide guidance to the interdisciplinary team. The Safe Resident Handling Program (SRHP) policy dated 7/7/25 indicated the SRHP provided interventions to provide caregivers the guidance for type of equipment, type of size of sling, and number of people to safely complete mobility tasks. The Stand Aid was used for residents who demonstrated leg strength for weight-bearing and were able to hold their torso in an upright position and pull themselves to a standing position. The responsibility of the staff was to eliminate manual lifting whenever possible by utilizing equipment and safe lifting practices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Specialty Care Community	3815 West Broadway Avenue Robbinsdale, MN 55422

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 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 interviews, observations, and document review the facility failed to ensure safe transfers for 1 of 3 residents (R1) who was lifted off the floor following a fall by two staff without using a Hoyer lift (mechanical lift used to transfer residents from one surface to another). In addition, two staff assisted R1 to stand from a wheelchair with a Stand Aid (non-motorized lift used to assist residents from a seated position to a standing position) without a gait belt.Findings include:R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 admitted to the facility on [DATE], was severely cognitively impaired, required staff assistance for transfers, and had diagnoses that included fractures and dementia. R1's care plan dated 3/23/26, indicated R1 required one staff to assist with toileting and transfers with a Stand Aid. During an interview on 5/13/26 at 8:32 a.m., R1's family member (FM)-A stated she was concerned staff were transferring R1 by two people moving R1 instead of the machine (Stand Aid) staff were supposed to use. The FM-A further stated she was concerned about how staff transferred R1 when they did use the Stand Aid because they did not have the required belt around R1 and pulled on R1's arms to get her out of the chair. FM-A stated she had videos of R1's transfers from the camera in R1's room. During an interview on 5/13/26 at 3:56 p.m., the nursing assistant (NA)-D stated she did not recall how R1 was supposed to transfer, but staff would refer to the therapy book on the counter of the nurses' station to know how each resident was supposed to transfer. The NA-D stated when a resident fell and an NA found the resident on the floor, the NA was supposed to get a nurse to assess the resident. If the resident was not injured the NA and the nurse would use a Hoyer lift to assist the resident from the floor. Staff used a Hoyer lift to prevent further injury and always used a Hoyer without exception. The NA-D did not recall helping R1. During an interview on 5/13/26 at 4:04 p.m., NA-C stated staff always used a Hoyer lift to assist residents off the floor after a fall. Staff could not lift the residents from the floor without a Hoyer lift, and a nurse had to be present. The NA-C stated she was supposed to use a Stand Aid to transfer R1.During an interview on 5/13/26 at 4:17 p.m., registered nurse (RN)-B stated after a resident fell, the nurses were supposed to assess the resident, take vital signs, perform neurological checks, and inform the resident's medical provider of the fall and assessment results. When a resident fell, the staff would use a Hoyer lift to get the resident off the floor, and staff were not allowed to just pick the resident up without the Hoyer lift. When staff utilized a Stand Aid for transfers, two staff were required, staff were supposed to use a gait belt around the resident for support as needed. Staff should not pull on the resident's hands or arms because it could injure the resident's shoulders. During a follow-up interview on 5/13/26 at 4:20 p.m., the NA-C stated she always used a Stand Aid with R1 and did not transfer R1 without it because R1 could fall. During an observation on 5/13/26 at 4:44 p.m. with the administrator and director of nursing (DON), of a video from the camera in R1's room, dated 3/30/26 at 8:17 p.m., two staff lifted R1 from the floor using R1's arms, without a gait belt or Hoyer lift. During an interview on 5/13/26 at 4:44 p.m. the administrator identified the two staff who lifted R1 off the floor without a Hoyer lift as RN-A and NA-D. The DON was present during the interview and the administrator stated using a gait belt to get a resident off the floor would be best practice. The DON stated the facility recommended staff use a Hoyer to get residents off the floor. The administrator acknowledged she was not sure what the facility policy indicated for transfers off the floor, but would look. During an interview on 5/13/26 at 4:49 p.m., the registered nurse (RN)-A stated she did not remember R1. The RN-A stated when a resident was found on the floor, the nurse was expected to perform an assessment, and then if the resident was not injured, staff would assist the resident off the floor with a Hoyer lift for the safety of the resident, and to not cause injury. During a subsequent interview on 5/14/26 at 10:09 a.m., the administrator stated she incorrectly identified RN-A, but instead staff licensed practical nurse (LPN)-A assisted to lift R1 from the floor. During an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Specialty Care Community	3815 West Broadway Avenue Robbinsdale, MN 55422

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 5/14/26 at 10:13 a.m., the LPN-A stated when a resident was found on the floor, staff assisted the resident off the floor, Per facility protocol. The LPN-A stated when she found R1 on the floor, she called for NA-D to help. The LPN-A stated she followed facility protocol to assist the resident from the floor with another staff and a gait belt. The LPN-A stated during orientation she was trained to assist a resident off the floor with a Hoyer but used her nursing judgment to get R1 off the floor with a two-person assistance instead. During an observation with the physical therapy assistant (PTA)-A on 5/14/26 at 10:40 a.m. of the video from the camera in R1's room dated 3/30/26 at 8:17 p.m., PTA-A acknowledged staff assisted R1 off the floor with a two-person lift instead of with a Hoyer lift. Additionally, upon review of another video from the same camera dated 4/3/26 at 8:14 p.m., staff utilized a Stand Aid with R1 and did not use a gait belt around R1 to assist with a lift from the wheelchair to a standing position but should have. With the position of the resident on the Stand Aid, the resident could have fallen backwards and staff would not have been able to stop the fall without the gait belt. During an observation with the administrator and clinical director (CD)-A on 5/14/26 at 11:00 a.m., of the video from the camera in R1's room dated 4/3/26 at 8:14 p.m., revealed staff transferred R1 with a Stand Aid without using a gait belt around R1, and staff used R1's hands to pull R1 to a standing position.During an interview on 5/14/26 at 11:00 a.m., both the administrator and CD-A were present. The administrator acknowledged staff did not utilize a gait belt during the Stand Aid transfer, but should have. The CD-A acknowledged all nursing staff were trained about safe transfers and knew what they were supposed to do but had not performed R1's transfer from the chair safely and had not safely assisted R1 from the floor.During an interview on 5/14/26 at 1:07 p.m., the director of nursing (DON) and administrator identified the staff who transferred R1 without a gait belt on the Stand Aid as NA-A and NA-B. During an interview on 5/14/26 at 1:34 p.m., the nursing assistant (NA)-A stated staff were trained to use a gait belt around the resident's waist when using a Stand Aid. The NA-A stated she was not sure what other staff did, but she preferred to transfer R1 with a two-person, without the Stand Aid. When R1 declined to use a Stand Aid, the NA-A would tell the nurse and then used a two person transfer instead. The NA-A stated she just did what the resident wanted. Further, the NA-A stated sometimes R1 could help stand herself up, and sometimes she could not. The NA-A acknowledged R1 could not make decisions about her own safety due to her diagnosis of dementia. During an interview on 5/14/26 at 1:49 p.m., NA-B stated the correct way for staff to utilize a Stand Aid with a resident was to use a gait belt when assisting the resident to stand. During an interview on 5/14/26 at 1:48 p.m., the DON stated the facility policy indicated when a resident fell, staff would utilize a Hoyer lift if space allowed, and R1's room contents could have been adjusted to allow for Hoyer use. When using a Stand Aid, staff were expected to use a gait belt around the waist of the resident so staff could help support the resident if the resident was unable to stand without assistance and to prevent falls. The Safe Resident Handling Program (SRHP) policy dated 7/7/25, indicated the SRHP provided interventions to provide caregivers the guidance for type of equipment, type of size of sling, and number of people to safely complete mobility tasks. The Stand Aid was used for residents who demonstrated leg strength for weight-bearing and were able to hold their torso in an upright position and pull themselves to a standing position. The responsibility of the staff was to eliminate manual lifting whenever possible by utilizing equipment and safe lifting practices.