STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	**725 E 10TH ST BOTTINEAU, ND 58318**

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 03/17/25 and concluded 03/20/25.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment.	F 640		4/24/25

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

Electronically Signed | 04/04/2025

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.

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F 640	Continued From page 1 (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure timely electronic data submission of a required Minimum Data Set (MDS) death discharge assessment for 1 of 1 closed record (Resident #18). Failure to follow the MDS data submission specifications did not meet the intended regulatory requirements. Findings include: The Long-Term Care Facility RAI 3.0 User's Manuel, revised October 2024, Page 2-38, stated, ". . . Death in Facility Tracking Record. . . Must be completed within 7 days after the resident's death . . . Must be submitted within 14 days after the resident's death. . . ."	F 640	1. Upon discovery, MDS transmitted the death discharge assessment for resident # 18 and it was accepted on 3/19/2025. 2. Any resident has the potential to be affected by this deficient practice. We reviewed all MDS's from the last 6 months and all have been exported. 3. MDS Coordinator, HIM and Social Services will be re-educated by GSS Senior Clinical Reimbursement Analyst on accurate MDS coding for death discharges through the MDS RAI Manual by 4/23/2025. New facility process: HIM will monitor weekly PCC MDS portal to verify all MDS' "export ready" have been transmitted 4. DNS or designee will audit 3 completed MDS's prior to transmission for accuracy of coding. Any incorrect coding identified will be immediately addressed. Audits will	

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F 640	Continued From page 2 Review of Resident #18's medical record occurred on 03/19/25. The MDS showed a Death in Facility Tracking Record, with an Assessment Reference Date (ARD) date of 01/17/25, as "Export Ready." During an interview on 03/19/25 at 1:50 p.m., two administrative staff members (#2 and #3) confirmed the facility failed to submit/export Resident #18's death discharge MDS, with an ARD of 01/17/25.	F 640	be completed 1x/week X 4 weeks, every other week X 2 months and then 1 X / quarter for 3 quarters. Audit results will be submitted to QAPI Committee for review and recommendations and ongoing monitoring or changing of frequency. 5.Completion date: April 24, 2025.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		4/24/25

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F 880	Continued From page 3 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 4 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 1 of 4 sampled residents (Resident #32) and 3 supplemental residents (Resident #15, #19, and #30) observed during personal cares. Failure to practice infection control standards related to enhanced barrier precautions (EBP), hand hygiene, and disinfecting equipment has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 03/19/25. This policy, dated March 2022, stated, ". . . use waterless alcohol-based hand sanitizer or soap and water to clean their hands: When entering patient room . . . After removing gloves regardless of task completed . . . After contact with a patient's non-intact skin, wound . . . excretions, mucus membranes, . . . When moving from contaminated body site to a clean body site during patient care . . . When exiting patient room . . ." Review of the facility policy titled "Standard and Transmission Based Precautions" occurred on 03/19/25. This policy, dated April 2024, stated, ". . . Enhanced Barrier Precautions (EBP) . . . refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [multi-drug	F 880	1. Nursing staff were re-educated on appropriate hand hygiene, glove use, cleaning equipment and EBP beginning on 3/28/2025 at shift change huddles. 2. Any resident has the potential to be affected by this deficient practice. 3. All staff will be re-educated on infection control practices, specific to hand hygiene, glove use, cleaning equipment and EBP, by Infection Preventionist with communication by compliance date. New facility process: charge nurse, DNS or Designee will observe moments of hand hygiene/glove use and cleaning of lifts after each use. 4. Infection Preventionist or designee will conduct observation audits of 5 staff members verifying proper hand hygiene, glove use, cleaning equipment and EBP practices. Audits will be completed 1x/week for 8 weeks, then every other week X 2 months and then monthly X 8 months. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendation. 5. Compliance Date: April 24, 2025.	

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F 880	Continued From page 5	F 880		

resistant organisms] to staff hands and clothing . . . are needed for residents with chronic wounds . . . High-Contact Resident Care Activities include: Transfers, dressing, assisting during bathing, providing hygiene, changing briefs or assisting with toileting . . . Resident/Patient Care Equipment and Instruments/Devices. . . . If common use of equipment for multiple residents/patients is unavoidable, clean and disinfect such equipment before use on another resident/patient . . ."

- Observation on 03/17/25 at 3:24 p.m. showed a certified nurse aid (CNA) (#4) applied gloves and assisted Resident #30 to sit on the toilet. The CNA lowered the resident's wet pants, and the soiled brief dropped to the floor. The CNA removed the wet pants and placed the soiled brief in the trash. Without changing gloves or performing hand hygiene, the CNA obtained a clean pair of pants and brief from the closet. The CNA (#4) cleansed the resident's perineal area with disposable wipes and used another wipe to clean a smear of bowel movement (BM) off the toilet seat, applied a clean brief, pants, and adjusted the resident's shirt. The CNA (#4) failed to change gloves and perform hand hygiene after she removed a soiled brief and wiped BM from the resident and toilet seat.

- Observation on 03/17/25 at 3:55 p.m. showed Resident #15 in bed. Two CNAs (#4 and #5) applied gloves, turned the resident, and removed the soiled brief. The CNA (#5) used disposable wipes to cleanse the perineal area of incontinent BM. The CNA (#5) applied a clean brief, pulled the resident's pants up, and emptied the garbage. Both CNAs placed the sling under the

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F 880	Continued From page 6	F 880		

resident and utilized a mechanical lift to transfer Resident #15 from the bed to a chair. The CNA (#5) removed her gloves, placed the mechanical lift in the hallway outside the resident room and failed to disinfect the mechanical lift after use. The CNA #5 failed to change gloves and perform hand hygiene after removing a soiled brief, cleansing the perineal area and before applying a clean brief.

- Observation on 03/17/25 at 4:10 p.m. showed Resident #19 in bed, two CNAs (#4 and #5) applied gloves and used a mechanical lift to raise the resident to a semi-standing position. The CNAs (#4 and #5) removed the resident's wet pants and brief. The CNA (#4) cleansed the resident's perineal area, applied a clean brief and pants, and transferred the resident to the wheelchair. The CNA (#5) placed the sit-to-stand lift in the hallway outside the resident room and failed to disinfect the lift after use. The CNA (#4) placed the foot pedals on the wheelchair, removed her gloves and performed hand hygiene. The CNA (#4) failed to change gloves after removing a soiled brief, cleansing the perineal area, and before applying a clean brief.

- Review of Resident #32's medical record occurred on all days of survey. The record identified an open sacral (base of the spine) wound. Review of the care plan identified, ". . . The resident requires Enhanced Barrier Precautions (EBP) R/T [related to] open wound. . . . Intervention: Don [apply] gown and gloves when performing high contact care activities including: dressing, bathing, transferring, . . . repositioning, checking and changing, . . ."

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F 880	Continued From page 7 Observation on 03/17/25 at 4:20 p.m. showed Resident #32's room with an EBP sign on the door frame. Two CNAs (#4 and #5) applied gloves, utilized a full-body mechanical lift and transferred Resident #32 from the recliner chair to the bed. The CNAs completed a brief change, and with the mechanical lift, transferred the resident into the wheelchair. The CNAs (#4 and #5) failed to apply gowns to complete high-contact care tasks for Resident #32. During an interview on 03/19/25 at 2:56 p.m., an administrative staff member (#2) confirmed she expected staff to change gloves and perform hand hygiene after removing soiled briefs, disinfect mechanical lifts after each resident use, and apply gloves and gowns for residents in EBP when providing high-contact care.	F 880		