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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 05/10/21 and concluded on 05/13/21.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide privacy during perineal cares for 3 of 9 sampled residents (Resident #9, #18, and #34). Failure to ensure privacy during perineal cares may lead to a resident's loss of dignity and is a violation of the resident's privacy. Findings include: Review of the facility policy "Beginning Five, Ending Five" occurred on 05/13/21. This policy, dated 03/08/21, stated, ". . . prior to and following any resident procedure . . . provide privacy . . ." Observations showed the following: * 05/11/21 at 8:05 a.m., A certified nursing assistant (CNA) (#4) provided perineal cares to Resident #34 without closing the privacy curtain. During the cares, another CNA (#5) entered the	F 557	1. This has been addressed with staff members (CNA #4, #5, #6 and Nurse #7) in regard Residents #9, #18 and #34. In the moment re-education on respecting resident's dignity and right to privacy was provided by the DNS on 5/13/21 when the issue was brought to the attention of administration. 2. All residents in the facility have to potential to be affected by this deficient practice. 3. Education was provided to all staff via point click Care, communication board and all staff in-service about protecting resident dignity on 6-7-21. Education was provided at an all staff in service on 6-7-21 meeting or prior to their next scheduled shift after this date. 4. An audit tool has been developed to monitor that doors or privacy curtains are	6/17/21

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

Electronically Signed | 06/11/2021

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 1 room. Staff failed to cover the resident ensuring privacy. * 05/11/21 at 10:56 a.m., A CNA (#5) transferred Resident #9 into bed and provided perineal cares without closing the privacy curtain. The CNA (#5) exited the room, left the door partially open, and returned with supplies. Staff failed to cover the resident ensuring privacy . * 05/12/21 at 4:10 p.m., A CNA (#6) provided perineal cares to Resident #18 without closing the privacy curtain. The CNA (#6) exited the room and failed to cover the resident. The CNA (#6) and a nurse (#7) reentered the room where staff failed to provide privacy for Resident #18. During an interview on 05/13/21 at 12:50 p.m., an administrative nurse (#1) and staff nurse (#5) both agreed the facility staff failed to follow the policy and provide privacy for Residents #9, #18, and #34.	F 557	closed or pulled while staff is doing resident cares. Audit will be completed by administrator or designee as scheduled: 3-5 residents' cares will be observed weekly x 4 weeks, then 2x weekly x 4 weeks, then 5 residents monthly x 5 months, then 5 residents quarterly x 2 quarters. 5. Date: 6-17-21	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		6/17/21

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 2 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the medical record for 2 of 13 sampled residents (Resident #6 and #10) accurately reflected the resident's advanced directive requesting DNR (do not resuscitate). Failure to ensure the medical record accurately reflected the resident/resident representative wishes has the potential to result in unwanted treatment. Findings include:	F 578	1. Resident #6 and Resident #10 POLST are up to date and accurate and E.H.R. reflects this. 2. All residents have the potential to be affected by this deficiency. 3. Education was provided to Unit Managers, HIM, and Social Services and policy was reviewed regarding managing of Advanced directives via email 5/19/21. These are the employees that are directly involved with advanced directives process. Charts audited to confirm all	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 3 Review of the facility policy "Advance Care Planning and Advance Directives-Rehab Skilled" occurred on 05/11/21. This policy, dated 01/14/2021, stated, ". . . Admission or Re-Admission . . . As necessary, physician will be contacted for orders that reflect the resident's wishes. Completed portable and enduring order forms (for example, POLST [Physician Orders for Life Sustaining Treatment]. . . (if adopted by the state) will be treated as physician's orders and placed in the medical record. . . ." Review of the facility policy "Physician/Practitioner Order/Skilled" occurred on 05/12/21. This policy, dated 11/20/20, stated, ". . . Order Templates/Order Sets . . . are designed to assist with the efficiency of order entry and specific components and details of orders such as admission, advance directives . . . Admission orders and orders received throughout the resident's stay are processed and transcribed . . . immediately upon receipt of the order. The orders must be noted by the licensed nurse . . ." - Review of Resident #10's medical record occurred on all days of survey. The computer banner identifies "ND POLST . . . DNR/Do Not Attempt Resuscitation . . ." Resident #10 signed/dated her choice for the ND POLST option of DNR on 05/20/20. The physician signed/dated Resident #10's ND POLST on 06/01/20, and nursing staff observed and entered Resident #10's ND POLST information into the EMR [electronic medical record] on 06/04/20, 15 days after resident made her wishes known. - Review of Resident #6's medical record occurred on all days of survey. The computer	F 578	current residents have advanced directives entered on 5/19/21. All current orders entered into PCC at this time. 4. An audit tool has been developed to monitor that all new admissions have advanced directives entered into medical record the day the orders return to facility. Audits will be completed by HIM as scheduled: All new admissions orders will be reviewed within 24 hours of admission x 4 weeks, then 2 new admission charts will be audited within 24 hours weekly x 4 weeks, then 2 new admissions charts will be audited within 24 hours monthly x 5 months, then 2 new admissions charts will be audited quarterly x 2 quarters. After above monitoring demonstrates expectations are consistently met monitoring may be reduced or discontinued. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes the above scheduled monitoring that demonstrates sustained compliance as approved by the QAPI committee and medical director. 5. 6-17-21	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 4 banner identifies "ND POLST (A): DNR/Do Not Attempt Resuscitation (Allow Natural Death)." The physician signed/dated Resident #6's ND POLST on 01/13/21 which showed the resident's representative chose, "(A): DNR/Do Not Attempt Resuscitation (Allow Natural Death)," nursing staff noted and entered into the EMR Resident #6's ND POLST on 01/26/21, 13 days after the physician's order. During an interview on the afternoon of 05/13/21, with two administrative nurses (#1 and #5) confirmed staff failed to enter orders in the EMR immediately for Resident #6 and #10.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, resident interview, and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 14 sampled residents (Resident #27) identified with a discrepancy coded on the MDS. Failure to accurately complete a MDS does not allow the residents' assessments to reflect their current status/needs. Findings include: Review of the facility policy titled "Long-Term Care - Minimum Data Set (MDS) System of Forms" occurred on 05/10/21. This policy, revised 01/2014, stated, ". . . long-term care	F 641	1. Resident #27 assessment has been corrected and resubmitted on 5/12/21. 2. This issue could impact all residents. An audit of all current MDS's section K was completed on 6/4/21 with no other residents having this section miscoded. 3. Food services manager was re-educated on 6-8-21 on correctly coding the MDS assessment. MDS coordinator will check MDS assessments for accuracy. 4. All Quarterly MDS section K's will be audited by MDS coordinator prior to submission for 3 months, then 50% of current MDS section K assessment will	6/17/21

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5 (LTC) facilities are required to conduct comprehensive, accurate . . . assessments of each resident's functional capacity and health status . . . primary purpose . . . payment of Medicare/Medicaid LTC services . . ." Review of Resident #27's medical record occurred on all days of the survey. Resident #27's quarterly MDS, dated 04/03/21, identified the facility coded, ". . . Nutritional Approaches . . . Feeding tube . . . Performed while a resident of this facility and within the last 7 days . . ." Review of physician orders, care plan, and diagnoses failed to provide documentation to support the resident has a feeding tube or receives nutrition by feeding tube. During an interview on 05/10/21 at 5:23 p.m., Resident #27 stated, "I have never had a feeding tube." During an interview on 05/12/21 at 11:30 a.m., a nurse (#4) verified she failed to accurately code nutritional approaches for Resident #27's recent MDS.	F 641	be audited for 3 month, then 25% of MDS section K for 3 months. After above monitoring demonstrates expectations are consistently met monitoring may be reduced or discontinued. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes the above scheduled monitoring that demonstrates sustained compliance as approved by the QAPI committee and medical director. 5. 6-19-21	
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		6/17/21

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 6 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interviews, the facility failed to provide the necessary services/treatments to prevent the development of pressure ulcers, promote healing, and prevent new ulcers from developing for 4 of 5 sampled residents (Resident #18, #34, #138, and #190) identified as having current/resolved pressure ulcers. Failure to evaluate risk factors that may impact the development/healing of a pressure ulcer, implement, monitor, and modify interventions to reduce those risk factors, and/or provide treatment to prevent new or heal current pressure ulcers may have contributed to Resident #18's venous ulcers/deep tissue injury with subsequent amputation, Resident #34 and #138's pressure ulcers, and #190's pressure ulcer/deep tissue injury. Findings include: Review of the facility policy titled "Wound and Pressure Ulcer Management" occurred on 05/13/21. This policy, dated 07/08/20, stated, ". . . management and treatment of surgical wounds, pressure ulcers, diabetic ulcers, and skin conditions, as well as arterial and venous ulcers . . . Braden, following interventions identified on care plan, nutritional intervention, specialty surfaces, etc. . . ." Review of the facility policy titled "Wound	F 686	1. Resident 18 Nutrition assessment was completed on 5/13/21 and was discussed in care plans on 5/18/21. Staff educated on the importance of following what is on the care plan, discussing the use of pressure relieving devices and consistency in charting. Discussion had at this time with staff on communicating these changes on the communication board in the electronic record. Fluid restriction was triggered for staff on MAR to be seen every shift 06/07/21. Sheets posted in resident room by DNS in secure area for fluid intake to be documented by staff upon exiting room 06/10/21. Education provided by DNS to dietary manager regarding timeliness and following orders assessments 6-10-21. Resident #138 Night staff that noticed wound on 5/10/21 to right heel was educated that all items are to be addressed when wound is discovered. Night nurse was made aware that there is a check list that has all items that need to be completed. This to include; the care plan and assessments appropriate for type of wound. Provider did rounds on 5/11/12 and ordered heel protectors and this was added to care	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 7 Dressing Change" occurred on 05/13/21. This policy, dated 07/16/20, stated, ". . . Check physician's order . . . Chart dressing change and wound observations on the Wound Data Collection [form]. . . If the RN needs to assess due to a change in the wound status and/or review the treatment choices, documentation should be completed on the Wound RN Assessment . . ." - Review of Resident #18's medical record occurred on all days of survey. Diagnoses include anemia, bursitis of left elbow, dependence on supplemental oxygen, hypertensive heart/heart failure, iron deficiency, peripheral vascular disease, protein-calorie malnutrition, stage 5 chronic kidney disease with dependence on renal dialysis, type 2 diabetes mellitus with hyperglycemia and neuropathy, and pressure/venous ulcers. The admission Minimal Data Set (MDS), dated 03/15/21, identified at risk of developing pressure ulcers, three arterial/venous ulcers, and required a pressure reducing device for chair and dressings to feet. The current care plan, revised 05/06/21, identified, "The resident has actual impairment to skin integrity R/T [related to] diabetes/venous insufficiency E/B [evidenced by] port to upper right chest and wounds to left toes and left heel . . . Monitor location, size and treatment of skin injury . . . Report abnormalities, failure to heal, s/s [signs/symptoms] of infection, maceration, etc. to health care provider . . . Weekly RN [nurse] assessment of venous wounds . . . Elevate heels off bed . . . Weekly skin observation by licensed nurse on Thursdays . . . Apply blue foam boot to left foot while in bed . . . Encourage resident to	F 686	plan 5/11/12 by unit manager. Survey team did bring to administrative staff on 5/13/21 prior to exit that staff member placing compression sock was informed by resident that it was painful when she was removing her compression stocking from her right foot. Staff member was educated immediately by wound nurse to alert nurse on floor if resident is experiencing pain. Resident #34 and #190 Staff educated immediately, on the importance of following what is on the care plan regarding pressure relieving devices when it was brought to the attention of administrative staff by survey team on 5/11/21. This education was completed by wound Nurse. 2. All resident at risk for skin breakdown have the potential to be affected by this practice. 3. We have implemented the following to be sure our facility stays in compliance with wound care and documentation: Individual Wound bags have been created for each wound that develops based on physician order for treatment. Resource guides have been created and implemented for wounds. Photo reminder cards placed at the head of each resident bed that is in need of heel protectors to remind staff to check placement. Regular nurses meeting instituted to review all assessment charting and notes for any possible needed changes. Will institute	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 8 eat protein foods . . ." A "Skin Observation" form, dated 03/11/21, identified, ". . . 1st and 5th toe raised area scabbed over less than 0.1 cm [centimeter] for length and width . . . left medial foot callus scabbed over and inflamed . . . 1st and 5th toe cleanse with dakins soaked gauze pat dry apply medihoney and cover with mepilex dressing. left medial foot cover with mepilex for protection . . ." A "Food and Nutrition Data Collection" form, dated 03/12/21, identified Resident #18 received, ". . . CCHO [carbohydrate-controlled diet], NAS [salt-controlled diet], Low Potassium diet . . . fluid restriction 1500 cc's [cubic centimeters] . . . skin problem(s)/risk noted by nursing . . ." A "Skin Observation" form, dated 03/18/21, identified, ". . . Right cracked heel . . . Left cracked heel . . . Left toes . . . Vascular ulcers to all but his 2nd toe . . . cleanse with dakins [wound care solution] soaked guaze pat dry apply medihoney [wound care dressing] and cover with mepilex [wound care dressing] or foam dressing on Tues, Thursday, and Saturdays . . ." A wound progress note, dated 03/23/21, identified, ". . . wounds . . . LEFT FOOT: 1st toe 0.3cm x [times] 0.4cm. 3rd toe 0.2cm x 0.4cm. 4th toe 0.5cm x 0.5cm. 5th toe . . . proximal wound 0.2cm x 0.4cm and distal wound 0.6cm x 0.9cm. BILATERAL HEELS: right 0.8cm x 0.9cm. left 2.0cm x 0.6cm. Wounds are all venous ulcers appearing red/brown in color, dry with no drainage . . . use skin prep over every wound daily . . ."	F 686	use of communication board on electronic health record to communicate any changes from wound nurse to nursing and nursing to wound nurse. Assigned education in Sanford Success Center to be completed by licensed nurses regarding documentation of wounds. These are assigned and required to be completed 6/16/21 or prior to next shift worked. Any dietary order received by nursing a copy is to be placed in dietary managers' box to review and adjust care as needed. Wound nurse (or designee) will send a copy of wound round paperwork to dietary manager each week and as needed to be updated to reflect current care needs. All residents at risk for pressure ulcers charts will be reviewed to ensure interventions are included on the care plan by 6-16-21. 4. Audits have been developed in regard to Physician orders/documentation consistency/pressure relieving devices and care plan interventions followed to monitor the issues with pressure areas. Audits will be completed by DNS/Wound Nurse or designee as scheduled Audits will be conducted of 3 residents at risk for pressure sores weekly X4 weeks, monthly X3 months quarterly x1 year. After above monitoring demonstrates expectations are consistently met monitoring may be reduced or discontinued. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes the above scheduled	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 9 A wound progress note, dated 03/30/21, identified, ". . . All seven venous wounds assessed . . . Great left toe 0.4cm x 0.4cm . . . 3rd left toe 0.2cm x 0.3cm . . . 4th left toe 0.6cm x 0.5cm . . . 5th left toe, proximal wound 0.9cm x 0.9cm . . . 5th left toe, distal wound 0.3cm x 0.4cm . . . Left heel 1.8cm x 0.5cm . . . Right heel 3.0cm x 4.5cm . . . right leg is very painful. Skin is very taught, warm and red in color . . . offload pressure to bilateral feet . . . Foam boots added to care plan . . ." A "Skin Observation" form, dated 04/01/21, identified, ". . . Monitoring scabs to 1st 3rd 4th toes to left foot. applying skin prep daily . . ." The wound progress notes identified the following: * 04/06/21, ". . . Left 1st toe 0.5cm x 0.5cm . . . 3rd left toe 0.3cm x 0.4cm . . . 4th left toe 0.3cm x 0.4cm . . . 5th left toe, proximal wound 0.9cm x 0.7cm . . . 5th left toe, distal wound 0.2cm x 0.3cm . . . Left heel 2.0cm x 1.5cm . . . Right heel 3.0cm x 4.5cm . . . All wounds are dark in color . . . pain to right leg . . . continue same treatment this week . . ." * 04/08/21, ". . . Capillary refill greater than 3 seconds . . . Presence of edema. Right leg tight and swollen . . . Antibiotic started . . . Clinic appointment today. Cellulitis to right lower leg diagnosed . . ." A "Skin Observation" form, dated 04/08/21, identified, ". . . Left lower leg . . . Redness/swelling present. 2+ pitting edema . . . left toes . . . Small, pinpoint ulcers to top of 1st, 3rd, 4th and 5th toes. Scabbed over. No bleeding	F 686	monitoring that demonstrates sustained compliance as approved by the QAPI committee and medical director. 6-17-21	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 10 or drainage . . ." A wound progress note, dated 04/13/21, identified, ". . . Left great toe 0.4cm x 0.4cm . . . 3rd left toe 0.2cm x 0.3cm . . . 4th left toe 0.3cm x 0.4cm . . . 5th left toe, proximal wound 0.9cm x 0.7cm . . . 5th left toe, distal wound 0.2cm x 0.3cm . . . Left ankle 2.0cm x 1.5cm . . . Right ankle 3.0cm x 4.5cm . . . continue with the daily skin prep to all wounds . . ." A wound progress note, dated 04/20/21, identified, ". . . Left great toe 0.4cm x 0.4cm . . . 3rd left toe 0.2cm x 0.2cm . . . 4th left toe 0.3cm x 0.4cm . . . 5th left toe, proximal wound 0.9cm x 0.7cm . . . 5th left toe, distal wound 0.2cm x 0.2cm . . . Left heel 2.0cm x 1.7cm . . . Right heel 3.0cm x 4.5cm . . . betadine daily to wounds . . ." A "Skin Observation" form, dated 04/22/21, identified, ". . . no skin issues observed . . ." The wound progress notes identified the following: * 04/27/21, ". . . Left great toe 0.9cm x 0.7cm . . . 3rd left toe 0.4cm x 0.3cm . . . 4th left toe 0.7cm x 0.4cm . . . 5th left toe, proximal wound 0.3cm x 0.2cm . . . 5th left toe, distal wound 0.6cm x 0.5cm . . . Left heel 2.0cm x 1.0cm . . . Right heel 3.0cm x 4.5cm . . ." * 04/29/21, ". . . suspected deep tissue wound to his right ankle measuring 2.6cm x 3.8cm . . . resident's right foot drops to the side causing pressure to both his outer ankle and heel . . . wound to right heel will now be followed as a suspected deep tissue wound instead of a venous ulcer. Today wound to right heel measures 3.8cm x 5.5cm. Both wounds are dark	F 686		

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 11	F 686		

purple to black . . . of bloody drainage from the wound to the outer right ankle . . . paint them [wounds] daily with betadine, same as the venous wounds to his left toes and left ankle . . . using boot with cutout heel . . . left in place at all times . . ."

A "Skin Observation" form, dated 04/29/21, identified, ". . . no skin issues observed . . . Applying betadine to area on left foot . . ."

Resident #18's primary physician ordered a nutrition assessment upon readmission to the facility. Dietary staff failed to complete the "Food and Nutrition Data Collection" form as ordered on 05/05/21.

A "Nursing Admit/Re-Admit Data Collection" form, dated 05/05/21, identified Resident #18 had "above the knee amputation . . . peri area is reddened . . . wounds to coccyx . . . left buttock . . . left knee . . . right lower leg . . . left heel [2], left 4th toe, 5th toe, and left great toe . . . Right lower leg AKA [above the knee amputation] [sic] site . . . left foot dusky . . . cool to touch . . . Pulses in left foot difficult to palpate [feel] . . . 45 staples . . . to surgical incision of right stump . . . Left arm/hand has 3+ [or greater] edema . . . 2+ edema . . . left foot . . . no nutrition issues . . . pain frequently . . ."

A "Skin Observation" form, dated 05/06/21, identified, ". . . Right antecubital discoloration . . . Coccyx open area . . . Right knee surgical incision . . . Left lower leg discoloration . . . Left lower leg . . . necrotic tissue areas . . ."

The wound progress note, dated 05/11/21,

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 12	F 686		

identified, ". . . Right BKA has a width of 24cm with 45 staples and is well approximated . . . pain with applied pressure . . . applying ABD [abdominal dressing] and wrapping with Kerlix [wound dressing] then ACE [elastic bandage] . . . Left great toe 0.5cm x 0.5cm . . . Left 4th toe 0.6cm x 0.5cm . . . Left 5th toe 0.5cm x 0.7cm . . . Left medial heel 2.5cm x 2.0cm . . . Left lateral heel 1.0cm 0.8cm . . . betadine daily . . . wrap leg from toes to knee with ACE wrap. Place boot with heel cut out to left foot. Keep leg elevated as resident allows . . . return from hospital stay wound to coccyx was coded as stage 1 pressure wound . . . now appears as deep purple in color and measures 3.0cm x 0.4cm . . . skin prep daily and offload pressure . . . wound to left buttock upon hospital return was noted as a stage 2. At this time wound is stage 3. Approximately 25% slough is noted to wound bed that measures 1.0cm x 1.0cm . . . Collagen powder moistened with anasept gel then cover with foam border dressing. Change daily . . . excoriation to the left side of his groin . . . apply calmoseptine BID [twice daily] . . . bruising to his left shin that measures 16cm in length . . . wrapping leg with ACE . . . KDU [kidney dialysis unit] 5/10/21 . . . remove 13 pounds of fluid. . . continue to have +2 and +3 pitting edema throughout his upper body and fluids noted to be seeping from his left arm . . . fluid restriction of 1500cc [cubic centimeters] daily . . ."

Observations showed the following:
* 05/11/21 at 10:44 a.m., Resident #18 laid in bed with left foot not elevated, pitting edema to left upper extremity and to right flank, hip, and thigh. An administrative nurse (#5) completed wound measurements for venous wounds to great left

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 13 toe, left 4th toe, left 5th toe; two pressure ulcers to left heel, Stage 3 pressure ulcer to left buttock, and deep tissue wound to coccyx. The administrative nurse (#5) also noted scabbed venous wound to left knee and pressure area to left shin. Staff failed to initial/date the coccyx dressing. * 05/12/21 at 8:35 a.m., Resident #18 laying in bed with left foot not elevated. * 05/12/21 at 4:10 p.m., Resident #18 laying in bed as staff provide cares, left heel not elevated prior to/after completion of cares. A CNA (#6) noted left groin reddened, moist, itchy, and painful. * 05/12/21 at 4:18 p.m., Resident #18 slid down in bed with left foot resting against the foot board, not elevated. Resident #18 unable to move his left leg from the current position. A nurse (#7) assessed the resident's left groin and applied ointment. The nurse (#7) provided wound cares/dressing changes to the resident's great left toe, left 4th toe, left 5th toe, two pressure ulcers to left heel, Stage 3 pressure ulcer to left buttock, and deep tissue wound to coccyx. The nurse (#7) applied lotion to the pressure area on his left shin. During cares, the nurse placed the resident's left heel directly on top of the wooden foot board. The nurse (#7) exited the room without elevating Resident #18's left heel. During an interview on 05/12/21 at 4:50 p.m., Resident #18 stated "My left groin is very sore and has been this way for about a month. Staff used powder on it once, put salve on it a couple times, but other than that have done nothing for it until today. They [staff] haven't even touched my toes [wounds] for three or four days."	F 686		

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 14	F 686		

During an interview on 05/13/21 at 11:44 p.m., an administrative nurse (#5) confirmed that nursing staff failed to consistently and accurately complete Resident #18's skin assessments; and failed to notify her regarding concerns of new wounds. The administrative nurse (#5) agreed that staff failed to follow the physician's order to elevate Resident #18's left heel.

- Review of Resident #34's medical record occurred on all days of survey. Diagnoses included anemia, malnutrition, reduced mobility, and pressure ulcer to left heel. The quarterly MDS, dated 04/11/21, identified at risk of developing pressure ulcers, one unhealed ulcer, required ulcer cares, dressings, nutrition interventions, a special mattress, and pressure relieving boots.

A current physician's order identified, ". . . heel protector boots to bilateral feet when in bed or whenever in a chair that heel is touching underlying surface . . ."

The current care plan identified, ". . . The resident has actual impairment to skin integrity R/T limited mobility, malnutrition, suspected deep tissue injury to left heel . . . left heel pressure area noted 04/19/21 . . . monitor location, size and treatment of skin injury . . . report abnormalities, failure to heal, etc to health care provider . . . place heel protectors to bilateral feet when in bed . . ."

Observations on 05/10/21 at 2:59 p.m. and 05/11/21 at 8:10 a.m. identified Resident #34 laid in bed with his heels directly on the bed. He was not wearing his pressure reducing boots at the time.

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 15 During an interview on 05/12/21 at 1:10 p.m., an administrative nurse (#1) stated staff should have ensured Resident #34 wore his heel protector boots. - Observations showed the following: * 05/11/21 at 5:34 p.m., Resident #138 slept in her recliner with her feet hanging over the footrest, pressure relieving heel boots on a chair. * 05/12/21 at 8:40 a.m., Resident #138 laid in bed with one heel boot on and the other off. * 05/12/21 at 9:45 a.m., A CNA (#6) pulled Resident #138's compression stockings over her right heel. Resident #138 stated, "Oo, oo that one, oo, ow, ow, mmm, ow." When the CNA (#6) put [Resident #138's] slippers on her feet, the resident stated, "Ow, it hurts." * 05/12/21 at 12:30 p.m., 3:20 p.m., and 4:30 p.m., Resident #138 laid in bed with her feet directly on the bed, heel boots on other bed. Facility staff failed to ensure Resident #138 wore her pressure relieving heel boots. Review of Resident #138's medical record occurred on all days of survey. Diagnoses included dementia and right heel decubitus ulcer. The current physician's orders identified, ". . . Betadine to deep tissue injury on right heel TID [three times a day] . . ." The orders failed to address her heel boots and repositioning schedule. The current care plan identified, ". . . The resident has impaired circulation R/T decreased mobility E/B edema to right knee and lower extremities . . . Elevate legs when sitting or sleeping and	F 686		

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 16 document . . . Compression stockings on in a.m. and off at HS [hour of sleep], as tolerated." The care plan failed to address her heel boots and repositioning schedule. The progress identified the following: * 05/06/21 at 11:05 a.m., ". . . Resident . . . right foot slightly edematous, non-pitting," and at 1:25 p.m., ". . . 2+ pitting edema noted to right knee and foot . . ." * 05/07/21 at 1:28 p.m., ". . . Communication . . . with Physician . . . New orders . . . Knee high compression stockings on in a.m. and off at HS [hour of sleep], as tolerated . . ." * 05/10/21 at 8:00 a.m., ". . . Resident noted to have a purplish discoloration present to right heel. Denies c/o [complained of] pain. area is non blanchable. Heels floated on a pillow to prevent pressure to area . . ." * 05/11/21 at 3:35 p.m., ". . . Resident seen by [Physician] on rounds . . . New orders given . . . New Right heel decubitus ulcer - heel boot, positioning q [every] 2hrs [hours], and betadine to ulcer TID [three times a day]," and at 8:26 p.m., "New deep tissue wound to right heel was assessed. Measures 3 cm x 2 cm. Wound is intact and deep purple in color . . ." During an interview on the afternoon of 05/13/21, both an administrative nurse (#1) and a managerial nurse (#7) confirmed Resident #138's orders and care plan failed to address her heel boots and repositioning schedule. The administrative nurse (#1) and managerial nurse (#7) also confirmed staff should have ensured Resident #138 wore her pressure relieving boots. - Review of Resident #190's medical record	F 686		

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 17	F 686		

occurred on all days of survey. Diagnoses included edema, hypertension, limited mobility, Type 2 diabetes mellitus, and impairment to skin integrity with suspected deep tissue pressure ulcer to right heel. The quarterly Minimum Data Set (MDS), dated 05/06/21, identified at risk for developing pressure ulcers, one unstageable pressure injury presenting as a deep tissue injury, and required ulcer cares, nutritional interventions, a special mattress.

A current physician's order identified, ". . . apply betadine to suspected deep tissue injury to right heel daily . . . provide blue foam pressure relieving/reducing boots for heels while in bed and in recliner . . ."

The current care plan identified, ". . . The resident has suspected deep tissue injury R/T immobility . . . purple intact wound to right heel . . . elevate heels off bed . . . Resident to wear blue foam heel pressure relieving boots while in bed and in recliner . . . skin observations by licenced [sic] nurse on Tuesdays . . ."

A wound progress note (written by the wound nurse), dated 05/04/21, stated ". . . suspected deep tissue wound measures 3.8 cm by 2.8 cm. Wound intact and purple in color . . . staff to place heel protectors while in bed. . . . betadine daily . . ."

Observations on 05/11/21 at 2:16 p.m. and 05/12/21 at 8:36 a.m. identified Resident #190 laid in bed with his heels directly on the bed. Staff failed to place Resident #190's pressure reducing boots on his feet.

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 18 During an interview on 05/12/21 at 10:04 a.m., an administrative nurse (#1) stated staff should have ensured Resident #190 wore his blue foam pressure relieving boots as care planned. As per facility policy and physician's orders, the facility failed to: * Notify the physician and wound nurse of Resident #18's deep tissue injury to coccyx and excoriated left groin, to receive timely wound/skin care and/or dressing changes, delaying treatment for seven days. * Update the care plan/care card at the time Resident #18's deep tissue injury to coccyx and excoriated left groin were first identified. * Update the physician's orders and care plan/care card at the time Resident #138's right heel ulcer was first identified. * Complete a "Food and Nutrition Data Collection" form assessing Resident #18's nutritional needs as ordered by the physician. * Ensure staff consistently implement pressure-relief measures for Resident #18, #34, #138, and #190.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy,	F 689	1. Resident #34 & #26 have had foot	6/17/21

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19 and staff interview, the facility failed to provide the assistive devices necessary to prevent accidents for 2 of 8 sampled residents (Resident #26 and #34) dependent on staff for transport. Failure to provide wheelchair foot pedals during transport may result in falls/injuries. Findings include: Review of the facility policy titled "OSHA [Occupational Safety and Health Administration] Nursing Department Safety Rules" occurred on 05/13/21. This policy, dated 01/22/21, stated, ". . . when transporting residents in wheelchairs . . . when a wheelchair is not self-propelled leg rests must be used . . ." Review of the facility policy titled "Departmental Safety" occurred on 05/13/21. This policy, dated 01/04/21, stated, ". . . transported to and from the department by wheelchair with foot pedals secured . . ." Observations showed the following: * 05/11/21 at 8:48 p.m., A CNA (certified nursing assistant) (#5) utilized one wheelchair foot pedal to transport Resident #34 down the hallway. One of Resident #34's shoe brushed the floor as the CNA (#5) transported her to the dining room. The CNA (#5) failed to cue Resident #34 to rest both feet on the single foot pedal and/or apply a second foot pedal prior to transport. * 05/11/21 at 9:39 p.m., A CNA (#3) transported Resident #26 down the hallway in her wheelchair. Resident #26's shoes brushed the floor as the CNA (#3) transported her. The CNA (#3) failed to cue Resident #26 to lift her feet and/or apply foot pedals during transport.	F 689	pedals placed on their Wheelchairs 5/14/21. 2. All residents who are in wheelchairs have the potential to be affected by this deficiency. 3. Education was communicated to all staff by DNS via Point Click Care-Communication Board regarding deficiency on May 14th, and June 8th, 2021. Training included safely transporting residents and appropriate assistive devices at all staff meeting on 6-9-21 and individually for those staff who could not attend the all staff education. 4. DNS or designee will audit 5 resident transports in wheelchairs weekly x 4 weeks, then 2 x weekly x 4 weeks, then 1 resident weekly x 3 months, then 5 residents quarterly x 2 quarters. After above monitoring demonstrates expectations are consistently met monitoring may be reduced or discontinued. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes the above scheduled monitoring that demonstrates sustained compliance as approved by the QAPI committee and medical director. 5. 6-17-21	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20 During an interview on 05/13/21 at 12:50 p.m., both an administrative nurse (#1) and a staff nurse (#5) stated they would expect staff to place foot pedals on wheelchairs prior to transporting residents and agreed that staff failed to follow the facility policy.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide respiratory care consistent with standards of practice and physician's orders for 1 of 1 sampled resident receiving oxygen (Resident #18). Failure to ensure changing of the oxygen tubing and humidifier bottle per policy may complicate a resident's respiratory status. Findings include: Review of the facility policy titled "Oxygen Administration, Safety, Mask Types" occurred on 05/12/21. This policy, revised 05/10/21, stated, ". . . To keep oxygen equipment clean and maintained in good condition . . . Disposable equipment should be changed weekly . . . and	F 695	1. Resident #18 had is tubing changed and dated correctly on 5/13/21 2. All current residents who receive oxygen therapy have the potential to be affected by this deficiency. 3. DNS provided education to Nurses/CMAs via Point Click Care-Communication Board 5/20/21 and again on 6/8/21. All nursing staff were educated on 6-9-21 at a mandatory all staff in-service or individually, education included reviewing the policy titled Oxygen Administration, Safety, Mask Types. 4. An audit tool has been developed to monitor that oxygen tubing and humidifier bottles are changed in accordance to our	6/17/21

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 21 marked with date and initials . . ." Review of Resident #18's medical record occurred on all days of survey. Diagnoses included chronic combined systolic (congestive) and diastolic (congestive) heart failure, respiratory failure with hypoxia, end stage heart failure, hypotension of hemodialysis, iron deficiency anemia, dependence on supplemental oxygen, emphysema, ischemic cardiomyopathy, and pulmonary hypertension. Current physician's orders include "Oxygen at 3 Liters via nasal cannula every day and night shift, oxygen per nasal cannula or face mask via O2 [oxygen] concentrator, portable and/or tank to keep Spo2 [oxygenation] above 90% [percent]. Every shift for shortness of breath, change oxygen tubing/humidifier bottle, and nebulizer [breathing treatment equipment] set-up . . . weekly on Wednesday . . ." Observation on 05/10/21 and 05/11/21 showed Resident #18's humidifier bottle dated 04/30/21 and oxygen tubing dated 04/13/21, both failed to identify staff initials. Observation on 05/12/21 and 05/13/21 showed Resident #18's humidifier bottle with no date or staff initials and oxygen tubing dated 04/13/21 failed to identify staff initials. Review of the Resident #18's Treatment Administration Record [TAR] showed staff documented humidifier bottle and oxygen tubing changes on 05/05/21. This contradicts the observations outlined above. During an interview on 05/13/21 at 9:21 a.m., an administrative nurse (#1) agreed staff should	F 695	policy. Audit will be completed by DNS or designee 3 times weekly x 2 weeks, then weekly x 4 weeks, then monthly x 2 months, then quarterly x 3 quarters. After above monitoring demonstrates expectations are consistently met monitoring may be reduced or discontinued. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes the above scheduled monitoring that demonstrates sustained compliance as approved by the QAPI committee and medical director. 5. 6/17/21	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 22 change humidifier bottle and oxygen tubing weekly, date and initial equipment, and document the completion on the TAR. The administrative nurse (#1) agreed failure to change oxygen equipment according to policy may complicate the resident's respiratory status.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interviews, the facility failed to provide care and services for the provision of hemodialysis consistent with professional standards of practice for 2 of 2 sampled residents (Resident #18 and #31) currently receiving dialysis. Failure to follow physicians' orders and/or care plan interventions and assess/monitor a resident prior to/after dialysis may result in staff failing to identify a change in the resident's status. Findings include: Review of the facility's policy titled "DIALYSIS SERVICES" occurred on 05/12/21. The policy, revised 04/06/21, stated, ". . . Clinical Monitoring - Dialysis UDA [assessment form] is available . . . for use in monitoring the resident receiving dialysis . . . "	F 698	1. Resident #18 chart has been updated on 5/19/21 to include required pre and post dialysis assessments. Resident#31 has been discharged from facility as of 5/12/21. 2. All residents receiving dialysis have the potential to be affected by this deficiency. 3. Education was communicated to all staff via Point Click Care, Communication Board on 5/19/21 and again on 6/8/21 regarding completion and entering physician orders, completing pre and post dialysis assessments, following fluid restrictions per policy if ordered, special instructions for any Blood Pressure directives. Facility implemented new Dialysis monitoring form on 5/19/21 and used revised form starting 6/10/21. Nursing supervisors will complete clinical Monitoring UDS post Dialysis. All nursing	6/17/21

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 23 - Review for Resident #18's medical record occurred on all days of survey. The current physician's orders identified, ". . . COMPLETE DIALYSIS UDA Q [every] MONDAY, WEDNESDAY, FRIDAY after dialysis . . . fluid restriction to 1.5L [liters]/day related to DEPENDENCE ON RENAL DIALYSIS . . ." The current care plan identified, ". . . The resident needs dialysis M [Monday], W [Wednesday], F [Friday] . . . The resident will have no s/s [signs and symptoms] of complications from dialysis . . . Monitor/document/report to health care provider PRN [as needed] for s/s [signs/symptoms] of the following: Bleeding, hemorrhage, bacteremia, septic shock . . . any s/s of infection to access site: Redness, swelling, warmth or drainage. Perma cath [dialysis port] to upper right chest. Fistula to right AC [antecubital], not currently being used for KDU [kidney dialysis unit] . . . Resident is on a fluid restriction. See charge nurse before giving any fluids between meals. Document all fluids provided . . ." Review of the "Dialysis UDA" forms, dated 03/22/21-05/12/21, identified staff failed to complete Resident #18's post dialysis documentation (including weights and vital signs) on six occasions. The progress notes identified the following: * 05/05/21 at 6:41 p.m., ". . . left foot has 2+ [plus] edema . . . left arm/hand has +3 edema . . ." * 05/07/21 at 9:39 p.m., "Hydration was completed and was very poor. Staff to encourage better fluid intake with and in between meals." This directly contradicts the physician's order for a 1.5 liters/day fluid restriction (1.5 liters = 1500	F 698	staff and dietary staff were educated on 6-9-21 at a mandatory all staff in service or individually for those who could not attend the all staff in service. 4. An audit tool has been developed to monitor if orders for dialysis have been entered and if residents on dialysis have had pre and post assessment completed, following fluid restrictions if any, special instructions for any Blood Pressure directives. Audit will be completed by DNS or designee as scheduled: Residents on dialysis chart will be audited 3 times weekly x 4 weeks, twice monthly x 3 months, quarterly as determined QAPI committee to ensure compliance has been met and expectations are consistently demonstrated. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes scheduled audits; then may be reduced or discontinued per QAPI once compliance is sustained as approved by the QAPI committee and medical director. 5. 6-17-21	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 24 mililiters). * 05/08/21 at 5:48 a.m., ". . . Lung sounds crackles to upper bases . . . incentive spirometer . . . 3 L oxygen via nasal cannula . . ." * 05/09/21 at 12:46 p.m., "Fax sent to [Physician] updating on . . . left arm edema . . . 2+ with clear drainage . . ." * 05/10/21 at 3:16 a.m., ". . . Resident has 2+ pitting edema to left extremities . . . edema to his abdomen, and right lower extremity above amputation . . . Abdomen is distended . . . clear fluid seeping from left arm . . ." * 05/10/21 at 8:32 a.m., ". . . resident has 3-4+ pitting edema to left arm that is seeping . . . Resident verbalizes he is unable to take a deep breath and cough . . . his breaths are shallow and cough is weak but productive. Lung sounds are diminished bilaterally . . . He appears slightly pale . . . above the [left] knee amputation . . . Does appear edematous . . ." Observations showed the following: * 05/10/21 at 10:44 a.m., Resident #18 laid in bed, noted edema to left upper extremity, intermittent non-productive cough, audible crackles, and nasal cannula oxygen in use at 2.5 L/min (minute). Resident #18 appeared short of breath when talking. No signage noted in Resident #18's room indicating no blood pressures on right arm due to dialysis fistula. * 05/11/21 at 10:44 a.m., Resident #18 had pitting edema to left upper extremity, right flank, right hip, and right thigh. Left upper extremity also noted to be weeping fluid. Resident #18 is noted to have intermittent non-productive cough and audible crackles, nasal cannula oxygen at 3 L/min, short of breath when talking, and repositioning self in bed.	F 698		

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 25	F 698		

* 05/12/21 at 4:10 p.m., Resident #18 had pitting edema to left upper extremity, right flank, right hip, and right thigh. Left upper extremity also noted to be weeping fluid. Resident #18 appeared short of breath when talking and while repositioning on bedpan. A certified nursing assistant (CNA) (#6) filled Resident #18's mug with 360 milliliters (ml) of water. Facility staff had already passed water three times that day. The CNA (#6) failed to document Resident #18's water intake and failed to notify the nurse of the additional fluids Resident #18 consumed. Review of Resident #18's fluids intake on 05/12/21 showed fluids on meal trays, three times a day water pass, water given with medication administration, and additional fluids given by the CNA (#6), totaling 2,160 ml (mililiters) of fluid throughout the day (660 ml over the physician ordered fluid restriction).

During an interview on 05/12/21 at 4:50 p.m., Resident #18 stated, "I am usually short of breath and have fluid in my lugs that has been going on for over a month. There should be a medication to help this. I had dialysis Monday [05/10/21] and they took off almost 15 pounds of fluid. I drink water because I am so dry. Staff have not offered sugar-free gum or hard candies to help with my dry mouth."

During an interview on 05/13/21 at 9:14 a.m., a nutrition supervisor (#2) indicated Resident #18 receives 200 ml of juice or water with each meal tray (for a total of 600 ml/day).

During an interview on 05/13/21 at 9:21 a.m., an administrative nurse (#1), indicated Resident #18 receives water in his mug three time a day (for a

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 26	F 698		

total of 1,080 ml/day) and she expects CNA staff to notify the nurse if they give him more water during the day. The administrative nurse (#1) confirmed staff had failed to complete "Dialysis UDA" forms after Resident #18's dialysis sessions.

- Review for Resident #31's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 04/13/21, identified the resident required dialysis. The orders failed to address her dialysis and/or blood pressure directives.

A hospital discharge summary, dated 04/07/21, identified, "To [Facility] . . . follow up in the dialysis unit monthly. The patient is going to be only on dialysis 3 times weekly, most likely Tuesday, Thursday, and Saturday. She will get iron IV [intravenous] Procrit and also no UF [ultrafiltration or removal of fluid] on dialysis."

The current care plan identified, ". . . The resident needs dialysis R/T [related to] Renal failure E/B [evidenced by] attends dialysis Tuesday, Thursday and Saturday, anemia due to CKD [chronic kidney disease] . . . The resident will have no s/s of complications from dialysis through the review date . . . Do NOT take blood pressure in right arm due to Permacath used for KDU [kidney dialysis unit] . . . Monitor/document/report to health care provider PRN [as needed] any s/s of infection to access site: Redness, swelling, warmth or drainage. Perma cath to upper right chest. No fistula in placed . . . Adjust medications on dialysis days as ordered . . . DIALYSIS MEAL: Send to dialysis with resident Tuesday, Thursday and Saturday . .

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 27 ." Review of the "Dialysis UDA" forms, dated 04/08/21-05/11/21, identified staff failed to complete Resident #31's post dialysis documentation (including weights and vital signs) on three occasions. During an interview on 05/12/21 at 4:50 p.m., a managerial nurse (#7) confirmed Resident #31's current physician's orders failed to address her dialysis and/or blood pressure directives. The managerial nurse (#7) stated, "We usually do that, have the orders on the summary." Failure to follow physicians' orders and/or care plan interventions may have contributed to Resident #18's deteriorating health status and failure to assess/monitor residents prior to/after dialysis may result in staff failing to identify a change in Resident #18 and #31's status.	F 698		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	F 725		6/17/21

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 28 by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, and resident, family, and staff interviews, the facility failed to provide sufficient nursing staff and related services to meet the residents' needs for 8 of 15 sampled residents (Resident #34, A, B, C, E, F, G, and H) who required staff assistance. Failure to provide sufficient staffing does not promote each resident's rights and physical, mental, and psychosocial well-being. Findings include: Observations on all days of survey showed five to ten residents seated around the nurses' station throughout the day. Staff occasionally interacted with the residents seated around the station and/or turned on a TV located near the activity room entrance/across from the nurses' station. Observation on 05/11/21 at 7:45 a.m. showed Resident #34 lying on the floor in front of the nurse's station after he fell out of his wheelchair.	F 725	1. 5/13/21 staff discussion led by DNS with PM and Noc nursing to redistribute nursing tasks the week of 5-31-21 – she worked several Noc shift and was able to evaluate work processes. Educated/reminded staff of utilization of communication systems that impact how staff function. Discussion with activities staff on how we can better accommodate resident needs including increasing activities (have hired additional FT activity aide, activity staff back from vacation). Moved 2 residents on 6-8-21 from East West Wing to North Wing to address care acuity issues to balance out areas. Approached corporate office to contract with agency CNA – approved and search started on 6-10-21. Increase in advertising to recruit staff – approved and in place 5-17-21 – includes sign on bonuses. Use of lifts was assessed and appropriate changes in care made which resulted in more	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 29 During interviews when asked if the facility had sufficient staff, residents, family members, and staff members made the following statements: * 05/10/21 at 5:23 p.m., Resident A's family member stated, "Sometimes it takes 20 minutes to an hour for them [staff] to answer her bell. [a longer wait] at night and on weekends. Saturdays and Sundays." * 05/10/21 at 5:47 p.m., Resident B stated, "They don't have enough staff. One nurse and one CNA [certified nursing assistant] girl at night. You have to wait for hours. Almost the same on the weekends. Sometimes they come in and turn the light off and leave again." * 05/11/21 at 8:42 a.m., Resident C stated, "No. Sometimes [I wait] a long time 20-30 minutes." * 05/12/21 at 4:10 p.m., Staff member D stated, "It's even hard to get someone to help turn a resident, because there is never enough staff." * 05/12/21 at 4:57 p.m., Resident E stated, "Sometimes it takes a long time for help. Late nights and weekends are worse." * 05/12/21 at 5:20 p.m., Residents F and G stated, "Many of us did not get a bath or shower this week, because of no staff. This happens a lot. We wait a long time on the late, late shift and weekends, for staff to answer our lights." * 05/13/21 at 10:10 a.m., Resident H stated, "I might miss [a bath], because I don't feel good. There are only two CNAs to keep track of this whole damn place (pointed to hall). It's as simple as that." * 05/13/21 at 10:45 a.m., Staff member I stated the activity department is short staffed, with one staff member trying to meet the needs of all the residents. * 05/13/21 at 11:21 a.m., Staff member J indicated the bath aides are oftened pulled from	F 725	ability to use 1 person transfers with some resident transfers. 2. All residents have the potential to be affected by this deficiency. 3. Administrator educated staff on customer service, call light response, and meeting ADL and other needs of residents on 6-9-21. Facility will continue to focus on recruitment efforts and use supplemental staffing agencies as needed to ensure adequate staffing levels. Education was provided in an all nursing staff on Interactions and Impact, and teamwork on 6/9/21 and individually to those who could not attend all staff in-service. Corporate Organizational Leadership Development team consulted 6/10/21 to assist with in-service content. Follow-up training will be conducted with all nursing staff on "Mindset, Interactions and Impact" via group and/or one on one meetings starting 6/16/21. Admissions limited for now until staffing is be improved. Increased sign on and referral bonuses implemented 6-10-21. 4. Social Services or designee will monitor via observations, Call light audits and resident & family interviews as scheduled: Resident and family interviews, and call light observations 2 times weekly x 4 weeks, twice monthly x 3 months, quarterly as determined QAPI committee to ensure compliance has been met and expectations are consistently demonstrated. All monitoring will be reported to the quality assurance process improvement (QAPI) committee	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 30 their duties, whenever the facility is short staffed on the floor. Failure to provide sufficient staffing negatively affected Resident A, B, C, E, F, G, and H's quality of life.	F 725	as part of QAPI activities. Monitoring will not be discontinued until the facility completes scheduled audits; then may be reduced or discontinued per QAPI once compliance is sustained as approved by the QAPI committee and medical director. 5. 6-17-21	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data	F 732		6/17/21

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 31 available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure timely posting of staffing information for 2 of 4 days of survey (May 12-13, 2021). Failure to post staffing data in a timely manner does not allow residents and visitors to be aware of the number of licensed/unlicensed staff directly responsible for resident care on each shift. Findings include: Observation of the daily staffing report occurred on all days of survey. Facility staff failed to post staffing data regarding the number of licensed/unlicensed staff directly responsible for resident care at the beginning of each shift on May 12th and 13th, 2021. During an interview on the afternoon of 05/13/21, both an administrative nurse (#1) and managerial nurse (#7) confirmed they expect facility staff to post the daily staffing report in a timely manner.	F 732	1. Day priors staffing sheet was removed at time of surveyor noticing incorrect staffing sheet, revealing current up to date staffing sheet. 2. No residents have the potential to be affected by this deficiency. 3. Education was communicated to all staff by DNS via Point Click Care-Communication Board regarding deficiency on 5/20/21, and 6/8/21. Education was provided at all staff in-service on 6-9-21 about posting staffing and individually to those staff who could not attend all staff. 4. The Administrator and/or designee will audit the posting for accuracy and timeliness as scheduled: 1 time weekly x 3 months, quarterly as determined QAPI committee to ensure compliance has been met and expectations are consistently demonstrated. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes scheduled audits; then may be reduced or discontinued per QAPI once compliance is sustained as approved by	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 32	F 732	the QAPI committee and medical director. 5. 6/17/21	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		6/17/21

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 33 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, professional reference, and staff interview, the facility failed to ensure the resident's medication regimen was free from unnecessary medications for 1 of 5 sampled residents (Resident #34) reviewed for psychotropic medications. Failure to evaluate Resident #34 for evidence for continued use of a psychotropic medication may have resulted in the resident receiving unnecessary medications and experiencing adverse drug effects related to their use. Findings include: Review of the facility handout titled "Tardive Dyskinesia" by the National Institute of Mental Health identified, "Tardive Dyskinesia, or TD, is one of the muscular side effects of anti-psychotic drugs . . . TD does not occur until after many months or years of taking antipsychotic drugs . . . the main symptoms of TD are continuous and random muscular movements in the tongue, mouth and face, but sometimes the limbs and	F 758	Initial AIMS testing found to not be completed on start of antipsychotic medication on Resident #34 Medication was started 3/16/21. Completed 5/12/21, with no noted abnormal movements. AIMS assessments are required prior to resident initially receiving an antipsychotic medication, within 3 days of admission/readmission if already on antipsychotic medication, and at least every 6 months when resident is receiving an antipsychotic medication. 2. All residents started on or currently on antipsychotic medications have the ability to be affected by this deficiency. 3. All charts were reviewed for residents currently on an antipsychotic medication on 5/27/21, each of these records are up to date on AIMS assessments. Current process for auditing AIMS completion is completed by HIM monthly. They also notify our contract pharmacist of any new	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 34 trunks are affected as well . . . The pattern and severity of TD is usually measured on a rating scale called 'The Abnormal Involuntary Movement Scale', (AIMS for short). Psychiatrists generally assess patients receiving long-term antipsychotic medication for TD symptoms at least annually using the AIMS . . ." During an interview on 05/12/21, a nurse manager (#1) verified the facility had no policy addressing AIMS testing and produced a copy of the AIMS. The scale stated, "Use . . . required prior to resident initially receiving an antipsychotic medication . . . required within 3 days of admission . . . at least every six months when resident is receiving an antipsychotic medication . . ." - Review of Resident #34 medical record occurred on all days of survey. Diagnoses included recurrent depression and anxiety. Medication orders included Seroquel (antipsychotic) 25 milligrams (mg) two times daily, dated 04/13/21. Resident #34's current care plan stated . . . "FOCUS: The resident uses antipsychotic medications related to depression and anxiety . . . GOAL: Resident will remain free of drug related complications, including movement disorder . . . Interventions . . . AIMS testing . . . admit . . . new medication . . . every six months and PRN [as needed] . . . " On 05/12/21 at 5:19 p.m., a nurse manager (#1) verified staff failed to complete an AIMS assessment since admit on 01/11/2021.	F 758	antipsychotics upon initiation. DNS educated Unit Managers on notifying DNS and HIM or designee who completes GDRs upon initiation of antipsychotics medications and when new residents are admitted or readmitted on an antipsychotic medication. Unit Managers are responsible for completing AIMS assessments as required. 4. An audit tool has been developed to monitor if AIMS assessments have been completed on residents who are on antipsychotic medications. Audit will be completed by HIM or designee as scheduled: 3-5 resident charts who are on antipsychotic medications or newly started on antipsychotic medications will be audited weekly x8 weeks, then 3-5 resident charts monthly x 4 months, quarterly as determined QAPI committee to ensure compliance has been met and expectations are consistently demonstrated. After above monitoring demonstrates expectations are consistently met monitoring may be reduced or discontinued. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes the above scheduled monitoring that demonstrates sustained compliance as approved by the QAPI committee and medical director. 5. 6-17-21	
F 801	Qualified Dietary Staff	F 801		6/17/21

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801 SS=E	Continued From page 35 CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the	F 801		

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801	Continued From page 36 requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure the dietary manager received the	F 801	1. No individual resident was directly affected by this practice	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801	Continued From page 37 necessary education to obtain the required qualifications to serve as the director of food and nutrition services for 1 of 1 dietary manager (#2). Failure to ensure qualified staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition services has the potential to result in adverse outcomes to residents, staff, and visitors. Findings include: During an interview on 05/10/21 at 11:47 a.m., the dietary manager (#1) identified beginning the Certified Dietary Manager (CDM) training but reported has not completed the course. During an interview on 05/12/21, at 1:15 p.m., an administrative staff member (#3) agreed the facility failed to ensure the dietary manager (#2) completed the required education for CDM. The facility failed to provide the necessary training in food and nutrition services to carry out daily operation duties.	F 801	2. All residents could possibly be affected by this deficient practice 3. The Supervisor of Food and Nutrition Services has enrolled in the “Certified Food Manager” (CFM) course through International Food Services Executives. Course was completed as of 6-11-21; certification obtained 6/16/21 following test taken 6/16/21. 4. Administrator will audit the completion of this course and file the certificate in this staff’s HR file. Any new food service manager will have required certifications or obtain certifications prior to working in Food Service Manager Capacity. After above monitoring demonstrates expectations are consistently met monitoring may be reduced or discontinued. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes the above scheduled monitoring that demonstrates sustained compliance as approved by the QAPI committee and medical director. 5. Date: 6/16/21	
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	F 880		6/19/21

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38 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 §483.70(e) and following accepted national standards; §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	F 880		

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39 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. §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, review of facility policy, and staff interview, the facility failed to follow infection control practices for 3 of 15 sampled residents (Resident #18, #33, and #34) observed during cares. Failure to practice infection control related to hand hygiene and glove use, disinfecting the urinary catheter bag tip, and cleaning equipment, has the potential for transmission of communicable diseases/infections to residents and staff within the facility. Findings include:	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of §483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for:	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40 Review of the facility policy, "Hand Hygiene and Handwashing" occurred on 05/13/21. This policy, revised 04/06/21, stated, ". . . use an alcohol-based hand rub for routinely cleaning hands . . . After having direct contact with another person's skin . . . After having contact with body fluids, wounds or broken skin . . . after removing gloves . . ." Review of the facility policy, "Environmental Cleaning Principles" occurred on 05/13/21. This policy, revised 12/16/20, stated, ". . . frequently cleaning high touch areas . . . between residents . . . Patient contact with equipment . . ." Observations showed the following: * 05/10/21 at 2:51 p.m., a certified nursing assistant (CNA) (#4) toileted Resident #34 after transferring him from his wheelchair to the bed utilizing a total lift. The CNA (#4) removed the lift from the resident's room after she completed his cares, parked the lift in a storage room, and walked away without cleaning the lift. The CNA failed to disinfect the lift after using it. * 05/11/21 at 8:25 a.m., a CNA (#5) bathed and toileted Resident #34 prior to transferring him from the bed into his wheelchair utilizing a total lift. The CNA (#5) failed to change her gloves and sanitize her hands after providing Resident #34's perineal and changing his urinary catheter bag to a leg bag. The CNA (#5) failed to clean the urinary catheter bag tip with an alcohol swab after allowing the catheter bag tip to touch the bed. After providing cares, the CNA (#5) removed the lift from the resident's room, pushed the lift to the storage room, and exited the room without cleaning the lift. The CNA failed to perform hand hygiene and clean/sanitize equipment.	F 880	(1) Ensuring staff are completing hand hygiene and donning gloves when appropriate, in accordance with CDC guidelines. (2) Ensuring staff are disinfecting equipment between multiple residents. (3) Ensuring staff are disinfecting the urinary catheter bag tip with an alcohol swab during cares and if urinary catheter bag tip touches contaminated surface. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff when hand hygiene and donning gloves must be performed. (2) Educate all staff when to disinfect equipment. (3) Educate all staff when to disinfect the urinary catheter bag tip. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 06/19/2021 the facility shall complete the following actions: (1) DON, IP, and applicable IDT members will conduct root-cause analysis	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41 * 05/11/21 at 10:20 a.m., a CNA (#8) cued Resident #33 to stand in the sit-to-stand lift and proceeded to cleanse her buttocks. When Resident #33 began urinating, the CNA (#8) assisted her back onto the toilet, removed her soiled gloves, and donned a new pair of gloves. The CNA (#8) failed to perform hand hygiene after removing her soiled gloves and prior to donning a new pair of gloves. * 05/12/21 at 4:10 p.m., a CNA (#6) donned gloves, provided Resident #18's perineal cares, removed her gloves, obtained Resident #18's mug, and exited the room. The CNA (#6) re-entered the room and assisted Resident #18 to drink from his mug. The CNA (#6) failed to perform hand hygiene after removing her gloves and prior to exiting the resident's room. During an interview on 05/13/21 at 12:54 p.m., an administrative nurse (#1) stated she expects staff to perform hand hygiene, clean urinary catheter bag tips, and disinfect lifts between residents. Failure to ensure staff follow infection control practices has the potential for transmission of communicable diseases/infections to residents and staff within the facility.	F 880	to identify and address the reasons for non-compliance related to: a. Failure to complete hand hygiene and don gloves when necessary. b. Failure to disinfect equipment when used with multiple residents. c. Failure to disinfect the urinary catheter bag tip after it touches a contaminated surface. (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff on the importance of hand hygiene and donning gloves and when both tasks must be performed. b. Educate all staff on the importance of disinfecting equipment when used with multiple residents. c. Educate all staff on the importance of disinfecting the urinary catheter bag tip after it touches a contaminated surface. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently	

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 _____	05/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 42	F 880	implemented and effective. Such monitoring will include: (1) Observation of all staff performing hand hygiene and donning gloves when necessary. (2) Observation of all staff disinfecting equipment used with multiple residents. (3) Observation of all staff disinfecting the urinary catheter bag tip if/when it touches a contaminated surface. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 06/19/2021	