STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	C 05/13/2025

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 An unannounced onsite complaint survey was completed on May 13, 2025. During the investigation the facility was found noncompliant with regulatory requirements.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		6/4/25

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

Electronically Signed | 06/09/2025

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F 580	Continued From page 1 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident's physician and/or resident representative of a change in condition for 1 of 1 closed record (Resident #1) who experienced a choking episode and 1 of 3 sampled residents (Resident #2) with a skin tear. Failure to notify the physician and/or resident representative of changes in condition may have prevented the physician from altering treatment/care and prevented the resident representative from making informed decisions regarding medical care. Findings include: Review of the facility policy titled "Notification of Change" occurred on 05/13/25. This policy, dated December 2024, stated, ". . . The facility must	F 580	1.Resident # 2's physician and family were notified of skin tear incident that was in Risk Management on 4/23/2025. 2.Any resident has the potential to be affected by this deficient practice. We reviewed all incidents within the last 6 months and identified 5 incidents without family notification. All notifications completed upon discovery. 3.All nursing staff will be re-educated by DNS or designee on GSS "Notification of Change" Policy and Procedure, specific to the facility must immediately inform the resident, consult with the resident's physician and notify the resident representative where there is an accident / incident, a significant change in condition, a need to alter treatment or a decision to transfer or discharge and	

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F 580	Continued From page 2 immediately . . . consult with the resident's physician and notify . . . the resident representative(s) when there is . . . A significant change in the resident's physical . . . status . . . A need to alter treatment significantly - a need to discontinue or change an existing form of treatment or to commerce a new form of treatment. . . ." - Review of Resident #1's medical record occurred on 05/13/25. The nurses' notes identified the following: * 03/22/25 at 8:45 a.m. ". . . Resident had choking episode. This nurse performed Heimlich [a first aid procedure used to dislodge an obstruction from a person's windpipe] on resident. Resident expelled a small chunk of food and large amount of phlegm. No adverse effects noted. . . ." * 03/24/25 at 9:26 a.m. ". . . Trial run of pureed food until diet order can be changed. . . ." * 04/04/25 at 3:37 p.m. ". . . [Resident #1's name] urine is very strong. Please push water and cranberry juice over the weekend. . . ." * 4/10/25 at 12:23 a.m. ". . . During routine rounds resident was discovered making usual loud, incomprehensible noises but with a somewhat wet sound. Pt [patient] discovered to have vomited their dinner up . . . Resident's light was already on as CNA [certified nurse aide] had already begun attending to resident's needs. Resident placed in high-fowler's [semi-sitting position where the head of the bed is elevated between 60 and 90 degrees] and oral suctioning provided with minimal vomitus suctioned into Yaunkur [medical tool used for suctioning secretions from the mouth and throat] (sic) tubing. . . . Resident w/ [with] no verbally	F 580	notification to be documented in PCC progress note. Re-education will be completed by compliance date. New facility process: Clinical IDT will review PCC 24/72 hour report and safe events each business day to validate all proper notifications with documentation have been completed, any missed notifications will be completed immediately upon discovery. 4.DNS or designee will conduct documentation audit of clinical IDT agenda form and resident medical record to validate notifications are completed with documentation. Any missed documentation will be immediately addressed. Audits will be completed 1x/week for 4 weeks, then every other week for 2 months and then 1 X / quarter for 3 quarters. All audit results will be submitted to the monthly QAPI Committee for review and recommendation. 5.Completion date: June 4, 2025.	

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F 580	Continued From page 3	F 580		

expressed needs. . . . resident's lungs w/congestion noted to all four fields. . . . Resident's v/s [vital signs] obtained and found to be hypotensive [abnormally low blood pressure] and tachycardic [fast heart rate]. Resident w/ [with] no other complaints throughout shift. Resident slept remainder of shift. . . ."
* 04/10/25 at 6:58 a.m. ". . . 0626 [6:26 a.m.] - Aide [CNA] came to this nurse . . . 79% [oxygen saturation] RA [room air] 0630 [6:30 a.m.] This nurse completed assessment; crackles to all lung fields with externally audible bubbling, O2 [oxygen] sats [saturation] rechecked via finger and ear with reading of 78% and 79%. O2 via NC [nasal cannula] at 3L[liters]/min [per minute] administered. 0635 [6:35 a.m.] - O2 rechecked via ear with reading of 82% 0640 [6:40 a.m.] - Family notified 0648 [6:48 a.m.]- Resident transported to ER [emergency room] 0650 [6:50 a.m.] . . ."

Resident #1's medical record failed to show the facility informed the resident's physician and representative of the choking episode, change in urine, and acute changes in the resident's status.

- Review of Resident #2's medical record occurred on 05/13/25. A nurse's note, dated 04/23/25 at 11:39 a.m., stated, ". . . Resident observed to have ST [skin tear] to posterior [back] upper Lt [left] leg near gluteal [buttock] crease measures approximately 0.3 cm [centimeters] in length by 0.5 cm in width measurements are approximate as Resident was moving . . . during measurement. Skin approximated [pulled together] and tegaderm [type of dressing] applied. . . ."

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F 580	Continued From page 4 Resident #2's medical record failed to identify the facility informed the resident's representative of the skin tear. During an interview on 05/13/25 at 4:28 p.m., an administrative nurse (#2) stated she/he would expect facility staff to notify Resident #1's medical provider and resident representative of the choking episode, change in urine, and acute changes in the resident's condition, and notify Resident #2's representative about the skin tear.	F 580		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to provide necessary care and services for 1 of 1 closed record (Resident #1) who experienced multiple medical incidents and a decline in health status. Failure to notify the provider and resident representative of the initial choking event and further medical incidents, delayed physician and representative input for testing/monitoring/treatment, contributed to the resident's decline followed by hospitalization, and may have contributed to the resident's subsequent death.	F 684	1.Resident #1 was from the closed records and has expired. On May 20, 2025 education to nurses on notifying leadership and family on resident events. 2.Any residents with a change of condition have the potential to be affected by this deficient practice. Upon chart review in the last 6 months 14 residents had a change of condition UDA with a change of condition UDA completed. 3.All licensed nurses will be re-educated by DNS on GSS Interact-Change of Condition Evaluation (CICE) Procedure,	6/4/25

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F 684	Continued From page 5 Findings include: Review of Resident #1's medical record occurred on 05/13/25. A Minimum Data Set (MDS)Assessment, dated 03/10/25, identified severely impaired cognition, and dependent on staff for all activities of daily living (ADLs). Review of Resident #1's progress notes identified the following: * 03/22/25 at 8:45 a.m. ". . . Resident had choking episode. This nurse performed Heimlich [a first aid procedure used to dislodge an obstruction from a person's windpipe] on resident. Resident expelled a small chunk of food and large amount of phlegm. No adverse effects noted. . . ." * 03/24/25 at 9:26 a.m. ". . . Trial run of pureed food until diet order can be changed. . . ." * A fax to Resident #1's medical provider, dated 03/31/25, stated, ". . . Resident continually yells out. Does not answer if asked questions such as if she needs something for pain. This behavior is not normal for her. It started on 3-30-25. . . ." The fax addressed the resident's new onset behaviors but failed to include the resident's choking episode on 03/22/25. * 03/31/25 at 1:45 p.m. ". . . Dietary is doing a trial of pureed diet to see how she does . . . Plan to continue to monitor & follow up in 1 month. . . ." * 04/4/25 at 3:37 p.m. ". . . [Resident #1's name] urine is very strong. Please push water and cranberry juice over the weekend. . . ." * 04/10/25 at 12:23 a.m. ". . . During routine rounds resident was discovered making usual loud, incomprehensible noises but with a somewhat wet sound. Pt [patient] discovered to	F 684	specific to following eINTERACT care paths / change of condition guidance for resident evaluation, UDA completion and provider notification. Education will be provided by compliance date. New facility process: copy of eINTERACT care paths / change of condition guide will be located at each nurses station. Clinical IDT will review PCC 24/72 hour report and safe events each business day to validate all proper notifications with documentation have been completed, any missed notifications will be completed immediately upon discovery. 4.DNS or designee will conduct documentation audit of clinical IDT agenda form and resident medical record to validate change of condition UDA completion when appropriate and notifications are completed with documentation. Any missed documentation will be immediately addressed. Audits will be completed 1x/week for 4 weeks, then every other week for 2 months and then 1 X / quarter for 3 quarters. All audit results will be submitted to the monthly QAPI Committee for review and recommendation. 5.Compliance Date: June 4, 2025.	

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F 684	Continued From page 6 have vomited their dinner up . . . CNA [certified nurse aide] had already begun attending to resident's needs. Resident placed in high-fowler's [semi-sitting position where the head of the bed is elevated between 60 and 90 degrees] and oral suctioning provided with minimal vomitus suctioned into Yaunkur [medical tool used for suctioning secretions from the mouth and throat] [sic] tubing. . . . Resident w/ [with] no verbally expressed needs. . . . resident's lungs w/congestion noted to all four fields. . . . Resident's v/s [vital signs] obtained and found to be hypotensive (abnormally low blood pressure] and tachycardic [fast heart rate]. Resident w/ no other complaints throughout shift. Resident slept remainder of shift. . . ." The facility failed to contact the resident's provider and representative related to vomiting, low blood pressure, and tachycardia. * 04/10/25 ". . . 0626 [6:26 a.m.] - Aide [CNA] came to this nurse to report . . . 79% [oxygen saturation] RA [room air] 0630 [6:30 a.m.] This nurse completed assessment; crackles to all lung fields with externally audible bubbling, O2 [oxygen] sats [saturation] rechecked via finger and ear with reading of 78% and 79%. O2 via NC [nasal cannula] at 3L[liters]/min [per minute] administered. 0635 [6:35 a.m.] - O2 rechecked via ear with reading of 82% 0640 [6:40 a.m.] - Family notified 0648 [6:48 a.m.]- Resident transported to ER [emergency room] 0650 [6:50 a.m.] . . ." The medical record failed to document a provider's notification and order for transport to the ER. * 04/10/25 at 2:45 p.m. ". . . Late entry 1130 [11:30 p.m.] Received report from . . . [name of hospital]. Resident will be admitted to comfort cares r/t [related to] aspiration . . . and sepsis."	F 684		

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F 684	Continued From page 7 The medical record failed to show facility staff consistently notified the provider and obtained orders to ensure proper care and services were provided to the resident after the choking episode, change of diet, odorous urine, and the change in condition on 04/10/25 at 12:23 a.m.	F 684		