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 05/24/2023

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

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F 000	INITIAL COMMENTS An unannounced onsite complaint survey was completed on May 16-17, 2023. Based on the findings, an extended survey was conducted on May 23-24, 2023.	F 000		
F 550 SS=K	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		6/23/23

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

Electronically Signed | 06/20/2023

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F 550	Continued From page 1 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation; information received from the complainant; review of the North Dakota Long Term Care Ombudsman Program's Guide to Resident Rights; and resident, family, and staff interview, the facility failed to treat residents with respect and dignity and care for residents in a manner and an environment that promotes, maintains, or enhances of their quality of life for 4 of 10 sampled residents (Resident #1, #2, #3, and #9) and 6 supplemental residents (Resident #13, #14, #15, #18, #19, and #20). Failure to protect residents from wandering and aggressive residents and the unwanted physical touch of a visitor violated their right to live in a safe environment free from abuse/neglect and resulted in negative psychosocial outcomes. During the on-site complaint survey, the team determined an Immediate Jeopardy (IJ) situation existed on 05/17/23 at 3:34 p.m. The IJ resulted from multiple resident interviews and observations regarding wandering and physically aggressive residents, and a visitor who comes to the facility. These findings placed residents in situations of feeling afraid and anxious in the environment causing the potential for negative psychosocial outcomes.	F 550	1. Immediate actions were taken by administrator on 5/17/2023 to ban the visitor of concern from property unless supervised by appointed staff in an appointment, allotted time: On 5/17/2023 at 8:33pm (visitor's son) and 8:37pm (visitor), were notified to inform them that visitor's visit to the facility must be supervised by staff through an appointment in allotted time if resident/s desire to have visitor. Staff appointed to supervise will allow scheduled visits in common areas only. The visitor may not wander alone throughout the building. If a staff member is not available to supervise, the visit will be re-scheduled. On 5/17/2023 at 8:46pm OnShift notice sent to all staff to instruct them to escort this visitor from the center unless he is supervised by appointed staff within allotted appointment time. On 5/17/2023 at 8:46pm, posted notification in nurse's station to (1) deny visit unless supervised by appointed staff	

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F 550	Continued From page 2 * 05/17/23 at 4:45 p.m. - The survey team notified the administrator and director of nursing of the IJ situation and requested they develop a plan for removal of the immediate jeopardy. * 05/18/23 at 3:41 p.m. - The survey team reviewed and accepted the facility's removal plan for the IJ. * 05/23/23 at 5:55 p.m. The team notified the administrator of the IJ removal. * On 05/23/23, the survey team verified the implementation of the removal plan and the IJ removal on 05/18/23. The deficient practice remained at an "E" scope and severity following the removal of the immediate jeopardy. Findings include: The North Dakota Long Term Care Ombudsman Program's Guide to Resident Rights, updated 03/21/23, stated, ". . . You cannot be subjected to verbal, sexual, physical, or mental abuse . . . You have the right to safe, clean, and comfortable surroundings . . ." Information received from the complainant identified concerns with aggressive/combative resident behaviors and wandering residents. The complainant stated a resident has hit other residents and staff and some residents are afraid to come out of their rooms. The complainant stated the wandering resident enters other residents' rooms at night, which scares them, and often takes their belongings. The complainant voiced concerns about a visitor who comes to the	F 550	within allotted appointment time. (2) Escort from facility if visiting not within appointment time or no appointed staff supervision. Immediate actions were taken by administration on 5/17/2023 related to behaviors of other residents: Administrator provided education to staff currently working on de-escalating and intervening if a resident becomes aggressive. Administrator started education 5/17/2023 at 10:10pm. Administrator educated staff on care planned interventions to address behaviors for resident # 5, # 6 and # 8. Administrator started education 5/17/2023 at 10:10pm On 5/17/2023 at 10:01pm, administrator sent OnShift notice that all-staff, in all departments, must complete this education at next shift. On 5/17/2023 at 6:18pm, Administrator started 1:1 supervision and developed schedule for staff and family to provide 1:1 supervision of resident # 5. This resident is being evaluated for needs and alternative placement. On 5/17/2023 at 9pm, administrator started and developed schedule for resident # 6, for staff to provide 15-minute routine checks for 3 days to monitor effectiveness of care plans interventions	

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F 550	Continued From page 3 facility and touches residents' faces, hands, and shoulders without permission, some of whom are non-verbal. - During an interview on 5/16/23 at 3:11 p.m., Resident #9 stated she has fears, anxiety, anger, and sometimes does not sleep due to other residents that reside within the facility. "When they [Residents #5, #6, and #8] are in my room or around me my anxiety shoots up to a ten plus-plus. I have brought my concerns to Resident Council, but nothing is done about it." - During an interview on 05/16/23 at 4:00 p.m., a staff member (#15) stated a visitor comes daily and is often seen touching the residents' faces and shoulders. She stated she observed the visitor "caressing" Resident #15's face, and the resident "looked scared, I saw her face." She stated the visitor came yesterday and was trying to touch two residents. One of the residents became very upset, "she [the resident] was going to get up and hit him." The resident stated, "Get the hell out of here" and "Don't touch me!" The other resident stated the visitor does this (touches them) often, and it makes her uncomfortable. The staff member (#15) further stated she has seen the visitor alone in residents' rooms, and one of the residents is "not coherent, she wouldn't be able to say if something happened." The staff member (#15) identified an incident when a resident (Resident #4) slapped another resident (Resident #5). The staff member (#15) stated staff do report incidents and voiced concerns regarding a lack of administrative follow-up after reporting of the incidents. - Observation on 5/16/23 at 4:07 p.m. showed	F 550	and a safe environment for all residents. We have also initiated conversations with the ombudsman about alternative placement. On 5/18/2023 at 7 pm, Administrator implemented intentional staff rounding for resident # 8, every 15 minutes from 7 pm to 7 am. Resident # 3 no longer resides in the facility. By 5/19/2023, residents #1, #2, and #9 were interviewed with safety / well-being questionnaire and trauma UDA assessments were completed. Resident # 1 and # 2 denied trauma with no changes noted in baseline moods and behaviors. Resident # 9 care plan updated from trauma UDA assessment. Resident #6 on paid hospital leave effective 6/11/2023. 2. All residents have the potential to be affected by this deficient practice. All current (46) residents were interviewed with safety / well-being questionnaire or if resident was unable to answer questions, was observed for change in their baseline by 5/19/23, 7 additional residents had trauma UDA assessment completed with no trauma experience or triggers identified.	

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F 550	Continued From page 4 the visitor identified in the complaint in the north lounge. He touched Resident #13's face while she played cards. He then stood near the residents playing cards and stared at them for some period of time. The visitor then sat beside Resident #14 and touched her face and hands multiple times and the resident pulled her hands away. Observation showed no facility staff present. - During an interview on 05/16/23 at 4:40 p.m., Resident #2 stated, "I don't feel safe here. It's very scary." Resident #2 stated there are several "mental patients." Regarding the visitor's interactions with residents, Resident #2 stated, "It is inappropriate. He is a problem. He doesn't want to leave." Resident #2 stated the residents have reported these concerns in Resident Council, and have stated, "We [the residents] don't feel safe here." - Observation in the dining room on 05/16/23 at 4:51 p.m. showed the visitor stood by Resident #15 holding onto the side of her wheelchair. Resident #15, visibly upset, stated, "[Visitor name], no, stop!" The visitor then moved to another table of residents, touched their shoulders, and came back to stand beside Resident #15 again. - During an interview on 05/16/23 at 5:05 p.m., Resident #1 stated she has seen Resident #5 hit other residents and staff, and is often unsupervised while wandering in the hallways, entering residents' rooms. Resident #1 stated on one occasion, Resident #5 was "on a rampage," and the facility had to call the cops and emergency medical services. Resident #1	F 550	3. All facility staff will be re-educated by administrator or designee on Resident Rights, specific to treating residents with respect, dignity and caring for residents in a manner and environment that promotes, maintains, and enhances quality of life by 6/22/233 or prior to next scheduled shift. 4. Social services designee will complete an interview with dignity/respect questions / observation to identify if resident's mood / behavior baseline has changed. Audits will be completed on 5 random residents 1 X / week for 2 weeks, then 5 random residents every other week X 2 , then 5 random residents 1 X / month for 2 months, then quarterly X 1. Any deficient practice will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations. 5. Compliance Date: 06/23/2023	

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F 550	Continued From page 5	F 550		

expressed frustration that Resident #5 returned to the facility a few hours later and was allowed to wander the hallways unsupervised again. Resident #1 further stated, "[The staff] don't do anything, they just redirect. What good does that do?"

- During an interview on 05/17/23 at 8:05 a.m., Resident #3 stated Resident #8 often enters her room at night. She woke up at 3:00 a.m. and Resident #8 was standing over her bed. When asked if she was afraid, Resident #3 stated, "Oh, yeah. My heart skipped quite a few beats." She stated Resident #5 "hasn't hit her yet but has given [me] mean looks. You don't know from one minute to the next if they'll smile or hit you." Resident #3 further stated, "This is getting way out of hand. I don't feel a bit safe here. I walk on pins because I'm afraid." Regarding the visitor, Resident #3 stated, "He gives me the creeps. He grabbed the back of my neck once. I let out a bellar, and he just laughed. They asked him to leave once and he wouldn't." Resident #3 stated the visitor has touched her many times, it was unwelcome, and "it feels creepy." Resident #3 added, "I didn't like that, it's inappropriate."

- During an interview on 5/17/23 at 8:16 a.m., Resident #14 stated she knows the visitor and does not care to talk with him or have him around her.

- During an interview on the morning of 05/17/23, Resident #20 reported she did not feel safe at the facility due to wandering and aggressive residents (Resident #5, #6, and #8).

- During an interview on 05/17/23 at 2:00 p.m.,

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F 550	Continued From page 6 Resident #19 stated, "I am afraid of [Resident #5]." - During an interview with the family of Resident #18 on 5/17/23 at 2:25 p.m., the family members voiced concerns of Resident #8 coming in and out of their mother's room, touching things, and sleeping in their mother's bed. The family also voiced concerns related to the visitor being around their mother and stated, "We do not want our mother touched by this man, we don't want him around her." During the onsite complaint investigation, resident and staff interviews identified concerns with wandering and aggressive residents, and a visitor who comes to the facility nearly every day. The behaviors of wandering and aggressive residents and the actions of the visitor violated the residents' right to a dignified existence in a safe environment that is free from abuse and neglect and placed residents at risk for psychosocial harm. Refer to F565, F600, and F744.	F 550		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their	F 585		6/23/23

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F 585	Continued From page 7 LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances	F 585		

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through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and

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F 585	Continued From page 9 (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainants, review of facility policy, review of monthly Resident group meeting minutes, and confidential resident interviews, the facility failed to act upon grievances expressed by 4 of 4 confidential residents (Resident A, B, C, and F) and 4 sampled residents (Resident #1, #2, #3, and #19). Failure to act upon the grievances regarding staffs' failure to change bed linens, manage other resident behaviors/wandering, and answer call lights in a timely manner resulted in continued resident dissatisfaction. Findings include: Information provided by the complainants identified concerns with extended call light response times and indicated staff failed to provide residents with weekly bed linen changes. Review of the policy "Call Light" occurred on 05/24/23. This policy, dated 10/21/22, stated, ". . . PURPOSE . . . To promptly answer a resident's call light. . . . " Review of the policy "Routine Practice" occurred on 05/24/23. This policy, dated 11/02/22, stated, "POLICY Routine practices are services that are expected to be provided to all residents . . . These guidelines are considered routine practice . . . Nursing . . . Change bed linens on bath day. . . ."	F 585	1. Resident #1 did not communicate personal grievance but attended resident group 5/25/2023. Resident #2 concern investigated with written follow up on 06/06/23. Resident # 3 was discharged to home on 5/18/2023. Resident #19 is dependent on staff for toileting with use of stand aid lift, is non-ambulatory. Re-education provided to facility clinical leadership team on GSS Policy and Procedure's: "Resident Group" and "Grievance, Suggestion or Concern" by GSS Social Services Consultant and GSS Recreational Wellbeing Consultant on 5/24/2023. Resident Group / Council was held on 5/25/2023 with written follow up on 06/06/23. 2. All residents have the potential to be affected by this deficient practice. All resident suggestions / concerns from completed forms and Resident Group / Council meetings for May 2023 were investigated with written response. 3. Facility will educate all residents / responsible parties of grievance process and provide "Resolving the Issues"	

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F 585	Continued From page 10 Review of the policy "Grievances, Suggestions or Concerns" occurred on 05/24/23. This policy, dated 11/07/22, stated, Purpose To document concerns, investigate findings and plan of correction . . . Grievances . . . are deemed to be high priority customer satisfaction issues and will be followed up on in the quickest time frame possible. . . . 3. . . . The individual will be told who will address the problem and provide a response that will include a time frame by which the issue will be addressed. . . ." Review of the December 2022-May 2023 Resident group meeting minutes identified the following: * 12/01/22, ". . . lights are being shut off at the desk and nobody coming to the rooms to shut them off, bed linens are not being changed . . . " * 01/05/23, ". . . Beds are not getting changed and linens are not getting passed. . . ." * 03/02/23, ". . . Lights are not being answered, staff are turning them off at the desk . . ." * 04/06/23, ". . . All of them [all eleven residents in attendance at resident group meeting] stated that the "wonderers" [sic] are going in and out of their rooms and taking things and laying in their beds. . . ." * 05/11/23 " . . . Wonderers [sic] are scaring residents in the middle of the night they are afraid . . . Residents do not feel safe or comfortable here anymore, to many wonderers [sic]. . . ." Resident interviews included the following: - During an interview on 05/16/23 at 12:08 p.m., Resident C stated, "It takes about 45 minutes for them [staff] to come help me when I put my light on". Resident C attends resident group meetings	F 585	brochure in conjunction with the admission agreement / admission process. The suggestion / concern forms with envelopes are accessible in 3 separate hallways of the facility. Signage was posted in each area, identifying Social Services Designee as Grievance Officer with routing instructions for completed forms on 06/14/2023. Facility process developed: Suggestions / Concerns lifted during Resident Group that cannot be immediately addressed and resolved, will be documented on Suggestion / Concern Form. Grievance Officer or designee will complete initial review and investigation upon receipt of suggestion / concern forms. The investigation team (Administrator, DNS, and Social Services Designee with clinical leadership input if indicated), will review and finalize investigation every Monday and Friday. The Grievance Officer will provide a written response to the suggestion form the writer. All facility staff will be re-educated on the GSS Grievances, Suggestion Concern P&P by administrator or designee by 06/22/23 or prior to next scheduled shift. 4. Administrator or designee will audit suggestion / concern forms and Resident Group minutes to verify timely investigation, action as indicated and written response to writer. 100% of suggestion / concern forms will be audited 1 X / week for 2 weeks, then 50% of	

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F 585	Continued From page 11 and stated, "I've told them [staff] at the resident group meetings lots of times." - During an interview on 05/16/23 at 3:11 p.m., Resident #19 stated, "I have to wait 20-30 minutes when I put my call light on. It bothers me because the wandering and aggressive residents could hit me or take/break my things before the call light is answered." Resident #19 also stated, "It's the worst [not answering the call light] when I'm sitting on the toilet and it takes them that long, my feet go numb. Sometimes I stand up, try to wipe, and try to pull my brief up. But I'm afraid I will fall. I don't know why it takes so long when they know they just put me on the toilet." - During an interview on 05/16/23 at 3:25 p.m., Resident A expressed concerns regarding bed linens not changed for at least two weeks and sometimes longer than two weeks. Resident A attends resident group meetings and stated, I have brought it up during the meetings and it doesn't ever get addressed". - During an interview on 05/16/23 at 3:30 p.m., Resident B expressed concerns regarding bed linens not changed for several weeks. Resident B attends resident group meetings and stated, "We have brought it up at the meetings, but it's been over two weeks now since they have changed my bed sheets". - During an interview on 05/16/23 at 4:40 p.m., Resident #2 voiced concerns regarding wandering and aggressive residents. Resident #2 stated she attends Resident group meetings, the residents have reported these concerns during the meeting, and have stated, "We [the residents] don't feel safe here." - During an interview on 05/16/23 at 5:05 p.m., Resident #1 expressed concerns regarding wandering and aggressive residents and	F 585	suggestion / concern forms will be audited every other week X 2, then 25% of suggestion / concern forms will be audited 1 X / month for 2 months, then quarterly X1. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee for review and recommendations. 5. Compliance Date: 06/23/2023	

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F 585	Continued From page 12 extended call light wait times. Resident #1 stated she attends the Resident group meetings, and the group has brought up these concerns before. - During an interview on 05/17/23 at 8:05 a.m., Resident #3 identified concerns with wandering and aggressive residents and extended call light wait times. The resident indicated she attends the Resident group meetings, and the group has discussed these concerns in the past. - During an interview on 05/17/23 at 8:10 a.m., Resident F stated, "It takes at least 30-45 minutes for anyone to answer my light the majority of the time". Resident F attends resident group meetings and stated, "It has been brought up by a lot of us in the past 4-5 months, but they don't do anything about it." The facility failed to make prompt efforts to resolve grievances and to keep the residents appropriately informed of progress towards a resolution.	F 585		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		6/23/23

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F 600	Continued From page 13 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation; information received from the complainant; record review; review of facility policy; and resident, family, and staff interview, the facility failed to ensure residents remained free from physical abuse and neglect for 4 of 10 sampled residents (Resident #1, #2, #3, and #9) and 6 supplemental residents (Resident #13, #14, #15, #18, #19, and #20) and failed to protect 2 of 2 sampled residents from resident to resident abuse (Resident #5 and #7). Failure to provide services necessary to avoid mental anguish and emotional distress resulted in fear, anxiety, an unsafe environment for residents, and actual psychosocial harm. During the on-site complaint survey, the team determined a potential Immediate Jeopardy (IJ) situation existed on 05/17/23 at 3:34 p.m. The IJ situation resulted from multiple resident concerns regarding wandering and physically aggressive residents, as well as a visitor who comes to the facility. This finding placed residents in immediate danger due to unresolved fear, anxiety, and an unsafe environment. * 05/17/23 at 4:45 p.m. - The survey team notified the administrator and director of nursing of the IJ situation and requested they develop a plan for removal of the immediate jeopardy. * 05/18/23 at 3:41 p.m. - The survey team reviewed and accepted the facility's written plan of correction for the IJ situation. * 05/23/23 at 5:55 p.m. - The survey team	F 600	1. Immediate actions taken by administrator on 5/17/2023: a. On 5/17/2023 at 6:18pm, Administrator started 1:1 supervision of resident # 5 and developed schedule for staff and family to provide 1:1 supervision of resident #5. Resident is being evaluated for needs and alternative placement. b. Provided education to staff currently working on de-escalating and intervening if a resident becomes aggressive and recognizing the signs of behavioral issues that may arise. Administrator started education 5/17/2023 at 10:10pm. c. Educated staff currently working on care planned interventions to address behaviors for residents # 5, #6 and #8. Administrator started education 5/17/2023 at 10:10pm. d. On 5/17/2023 at 10:01pm, Administrator sent OnShift notice that all-staff, in all departments, must complete the education at next shift. e. On 5/17/2023 at 9pm, administrator started and developed schedule for resident # 6, for staff to provide 15-minute routine checks for 3 days to monitor effectiveness of care plans interventions and a safe environment for all residents.	

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F 600	Continued From page 14 removed and reduced the IJ situation from a scope/severity of K to a scope and severity of E. Findings include: Information received from the complainant identified concerns with aggressive/combative resident behaviors and wandering residents. The complainant stated a resident has hit other residents and staff and some residents are afraid to come out of their rooms. The complainant stated the wandering resident enters other residents' rooms at night, which scares them, and often takes their belongings. The complainant voiced concerns about a visitor who comes to the facility and touches residents' faces, hands, and shoulders without permission, some of whom are non-verbal. Review of the facility policy titled "Abuse and Neglect" occurred on 05/24/23. This policy, dated 10/13/22, stated, ". . . Purpose . . . To ensure the location has an effective system in place that, regardless of the source, prevents mistreatment, neglect, exploitation, and abuse of residents and misappropriation of their property . . . To ensure that residents are not subjected to abuse by anyone, including, but not limited to, location employees, other residents, consultants or volunteers, employees of other agencies serving the individual, family members or legal guardians, friends or other individuals . . . Alleged or suspected violations involving any mistreatment, neglect, exploitation, or abuse including injuries of unknown origin will be reported immediately to the administrator. In the absence of the administrator from the location, the following individuals have the administrative	F 600	f. On 5/18/2023 at 7pm the Administrator will implement night schedule for #8, for staff to provide intentional rounding on residents whereabouts every 15 minutes from 7pm-7am g. On 5/17/2023 at 8:33pm (visitor's son) and 8:37pm (visitor), were notified to inform them that visitor's visit to the facility must be supervised by staff through an appointment in allotted time if resident/s desire to have visitor. Staff appointed to supervise will allow scheduled visits in common areas only. The visitor may not wander alone throughout the building. If a staff member is not available to supervise, the visit will be re-scheduled. h. On 5/17/2023 at 8:46pm OnShift notice sent to all staff to instruct them to escort this visitor from the center unless he is supervised by appointed staff within allotted appointment time. i. On 5/17/2023 at 8:46pm, posted notification in nurse's station to (1) deny visit unless supervised by appointed staff within allotted appointment time. (2) Escort from facility if visiting not within appointment time or no appointed staff supervision. Resident # 3 no longer resides in the facility. By 5/19/2023, residents #1, #2, and #9 were interviewed with safety / well-being questionnaire nurse or administrator and trauma UDA assessments were completed. Resident #	

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F 600	Continued From page 15 authority of the administrator for purposes of immediate reporting of alleged violations: the director of nursing services or the supervisor of social services. These designated individuals are delegated the authority by the administrator to: 1. Intervene in any situation in order to protect the residents. 2. Remove any individual from the location if necessary for the protection of residents or employees, including but not limited to employees, visitors, contractors, or family members. 3. Call local law enforcement for assistance with interventions necessary for the protection of residents or employees. 4. Call 911 for any type of emergency assistance. The location will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in process. . . ." - Observation on 05/16/23 at 11:43 a.m., showed Resident #6 yelling profanities by the dining room entrance, hitting the wall, and banging the phone on the wall. The resident then walked into dining room, continuing to yell profanities and throwing her walker. Staff observing made no attempts to intervene. - During an interview on 5/16/23 at 3:11 p.m., Resident #9 stated she has fears, anxiety, anger, and sometimes does not sleep due to other residents that reside within the facility. Resident #9 stated, "At night when I can't sleep it's because I'm afraid to wake up and see who is standing above me." She goes onto state "During the day when I'm in my chair I am helpless because I can't move. I've had residents [#5, #6, and #8] in my room all at one time fighting with each other, picking up my things, and yelling	F 600	1 and # 2 denied trauma with no changes noted in baseline moods and behaviors. Resident # 9 care plan updated from trauma UDA assessment. Resident #6 on paid hospital leave effective 6/11/2023. 2. All residents have the potential to be affected by this deficient practice. All current (46) residents were interviewed with safety / well-being questionnaire or if resident was unable to answer questions, was observed for change in their baseline by 5/19/23, and no neglect or abuse triggers were identified. 3. All facility staff will be re-educated by administrator or designee on GSS Abuse and Neglect Policy and Procedure including facility specific procedure for reporting by 6/22/23 or prior to next scheduled shift. 4. Resident interview / Observations Audits will be completed by DNS or designee for care concerns or change from baseline. Audit will be for 5 random residents 1 X / week for 2 weeks, then 5 random residents every other week X 2, then 5 random residents 1 X / month for 2 months, then quarterly X1. Any deficient practice will be addressed immediately. All audit results will be submitted to the	

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F 600	Continued From page 16 profanities, one time [Resident #5 name] came rushing at me, I thought she was going to hit me but all she did was throw my oximeter at me." Resident #9 states that shes does put on her call light, but it doesn't get answered for some time and by then one of these residents could have hit her or taken/broken her things. "When they [Residents #5, #6, and #8] are in my room or around me my anxiety shoots up to a ten plus-plus. I have brought my concerns to Resident Council, but nothing is done about it." - During an interview on 05/16/23 at 3:30 p.m. with Resident #9, observtion showed Resident #5 and #8 entered the room without knocking. The residents picked up Resident #9's belongings and moved them around. Resident #5 approached Resident #9 and touched her things on her overbed table. Resident #9 asked the residents to leave her room, but they continued to linger, argue, and eventually left the resident's room. Resident #9 expressed anxiety and angry and wished something could be done about this. - During an interview on 05/16/23 at 4:00 p.m., a staff member (#15) stated a visitor comes daily and is often seen touching residents' faces and shoulders. She stated she observed the visitor "caressing" Resident #15's face, and the resident "looked scared, I saw her face." She stated the visitor came yesterday and was trying to touch two residents. One of the residents became very upset, "she [the resident] was going to get up and hit him." The resident stated, "Get the hell out of here" and "Don't touch me!" The other resident stated the visitor does this (touches them) often, and it makes her uncomfortable. The staff member (#15) further stated she has seen the	F 600	monthly QAPI Committee for review and recommendations. 5. Compliance Date: 06/23/2023	

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F 600	Continued From page 17	F 600		

visitor alone in residents' rooms, and one of the residents is "not coherent, she wouldn't be able to say if something happened." The staff member further identified an incident of a resident (Resident #4) slapping another resident (Resident #5). The staff member stated staff do report incidents and voiced concerns regarding a lack of administrative follow-up after reporting of the incidents.

- Review of Resident #5's medical record occurred on all days of survey. A nurse's note, dated 05/06/23, stated, ". . . Res. continues to walk into other residents [sic] rooms. She was slapped in the face by another resident today in the evening for
wanting to take her walker. No injuries. They were both redirected. . . ." Refer to F607.

- Observation on 5/16/23 at 4:07 p.m. showed the visitor identified in the complaint in the north lounge. He touched Resident (#13) face while she played cards. He then stood near the residents playing cards and stared at them for some period of time. The visitor then sat beside Resident #14 and touched her face and hands multiple times and the resident pulled her hands away. Observation showed no facility staff present.

- During an interview on the afternoon of 05/16/23, a staff member (#17) identified the visitor has touched her "butt" during one of his visits. She reported the incident to administration but no action was taken.

- During an interview with Resident #2 on 05/16/23 at 4:40 p.m., the resident stated, "I don't

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F 600	Continued From page 18	F 600		

feel safe here. It's very scary." Resident #2 stated there are several "mental patients." She stated Resident #6 is "rowdy, cussing and swearing. [She is] fine one minute, and then she freaks out. They had to call the cops." She stated regarding Resident #8, "Half the time, they can't find her. She goes in everyone's rooms, finds an empty bed and she's sleeping in it. She steals things, and [the items] end up in someone else's room." Resident #2 stated she was sleeping, "and I woke up and she's [Resident #8] standing over me." Resident #2 stated regarding Resident #5, "All of a sudden she'll lash out. She's real feisty. She's punched staff." Resident #2 stated Resident #5 "tried to hit me a month ago. I protected myself with my walker," and "[Resident #5] came up to me and started hitting at me, she's been in my room several times." Regarding the visitor, Resident #2 stated, "It [his touching of residents and staff] is inappropriate. He is a problem. He doesn't want to leave [when he visits]." Resident #2 stated the residents have reported these concerns in Resident Council, and have stated, "We [the residents] don't feel safe here."

- Observation in the dining room on 05/16/23 at 4:51 p.m., showed the visitor stood by Resident #15 holding onto the side of her wheelchair. Resident #15 was visibly upset, stated, "[Visitor name], no, stop!" The visitor then moved to another table of residents, touched their shoulders, and came back to stand beside Resident #15 again.

- During an interview with Resident #1 on 05/16/23 at 5:05 p.m., the resident stated Resident #8 has come into her room "many

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times," she threw a shoe at her once, and she takes things that don't belong to her from other resident's rooms. Resident #1 reported that Resident #5 hits other residents and staff. Resident #1 stated, "If she (Resident #5) ever tried anything, I wouldn't be able to fend for myself." The resident further stated, "Afraid? Not exactly, but I would say cautious. They (Resident #5, #6, and #8) make me uneasy." Regarding the visitor, Resident #1 stated he "weirds them (the residents) out."

- During an interview with Resident #3 on 05/17/23 at 8:05 a.m., the resident stated Resident #8 often enters her room at night. She woke up at 3:00 a.m. and Resident #8 was standing over her bed. When asked if she was afraid, Resident #3 stated, "Oh, yeah. My heart skipped quite a few beats." She stated Resident #5 "hasn't hit her yet but has given [me] mean looks. You don't know from one minute to the next if they'll smile or hit you." Resident #3 further stated, "This is getting way out of hand. I don't feel a bit safe here. I walk on pins because I'm afraid." Regarding the visitor, Resident #3 stated, "He gives me the creeps. He grabbed the back of my neck once. I let out a bellar, and he just laughed. They asked him to leave once and he wouldn't." Resident #3 stated the visitor has touched her many times, it was unwelcome, and "it feels creepy." Resident #3 added, "I didn't like that, it's inappropriate [for him to touch her]."

- During an interview on 5/17/23 at 8:16 a.m., Resident #14 stated she knows the visitor and does not care to talk with him or have him around her.

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F 600	Continued From page 20 - Observation on 05/17/23 at 8:45 a.m., showed Resident #6 in the main hallway by the dining room. The resident picked up her front wheeled walker (FWW) and threw it down the hallway where other residents were present. - During an interview on the morning of 05/17/23, Resident #20 reported she did not feel safe at the facility due to wandering and aggressive residents (Resident #5, #6, and #8). - During an interview on 05/17/23 at 2:00 p.m., Resident #19 stated, "I am afraid of [Resident #5]." - During an interview with the family of Resident #18 on 05/17/23 at 2:25 p.m., the family members voiced concerns of Resident #8 coming in and out of their mother's room, touching things, and sleeping in their mother's bed. The family also voiced concerns related to the visitor being around their mother and stated, "We do not want our mother touched by this man, we don't want him around her." - Review of facility incident reports occurred on 05/24/23. A report, dated 04/25/23, stated, ". . . This resident [Resident #7] was hit with a closed fist to the chest by [Resident #5] while he was doing exercises. . . ." Another report, dated 04/25/23, stated, ". . . Resident [#5] walked into therapy room and grabbed resident [#7] by the shirt and punched resident with a closed fist. . . ." - During an interview on 05/17/23 at 2:55 p.m., when asked if other residents come into his room Resident #7 stated, "[Expletive] yeah but I'm not afraid of them, I'm just gonna [expletive] hit them	F 600		

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	355093	A. BUILDING _____ B. WING _____	C 05/24/2023

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GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 600	Continued From page 21 and that will keep them from coming back." During an interview on 05/17/23, a social services staff member (#14) stated the visitor makes some residents and staff uncomfortable, and "He scares other residents. He just sits there and stares at them." The staff member stated the residents brought up the visitor at Resident Council last week. The staff member also stated there have been issues of Resident #5 hitting staff or hitting other residents. The staff member identified she has reported the incidents to management but has not gotten a response. During an interview on 05/17/23 at 12:15 p.m., the facility's medical director stated she was unaware of the visitor coming to the facility, and agreed his behavior was inappropriate. The facility failed to protect residents from wandering and combative residents and the unwanted physical touch of a visitor. These failures resulted in fear, anxiety, an unsafe environment for residents, and actual psychosocial harm. Refer to F550, F565, F607, and F744.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures	F 607		6/23/23

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F 607	Continued From page 22 to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on information received from the complainant, record review, review of facility policy, and staff interview, the facility failed to implement policies and procedures related to abuse for 1 of 2 sampled residents (Resident #4) who struck another resident. Failure to report and investigate an incident of resident-to-resident abuse placed all residents at risk of physical abuse. Findings include: Information received from the complainant identified concerns with resident-to-resident abuse.	F 607	1. Upon discovery (05/24/2023) of resident-to-resident incident a risk management incident reports completed for resident #4 and resident #5 with investigation. Facility developed facility specific procedure for reporting allegations of abuse and neglect. 2. All residents have the potential to be affected by this deficient practice. 3. All staff will be re-educated on GSS Abuse and Neglect Policy and Procedure with facility specific reporting procedure by administrator or designee by	

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F 607	Continued From page 23 Review of the facility policy titled "Abuse and Neglect" occurred on 05/24/23. This policy, dated 10/13/22, stated, ". . . To ensure that residents are not subjected to abuse by anyone, including, . . . other residents . . . Alleged or suspected violations involving any mistreatment, neglect, exploitation, or abuse including injuries of unknown origin will be reported immediately to the administrator. . . . The location will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. . . ." - Review of Resident #4's medical record occurred on 05/23/23. A nurse's note, dated 05/06/23, stated, ". . . This res. [resident] got into a conflict c [with] another res. over resident wanting to take walker away from her. This res. slapped 307 [Resident #5] in the face. No injuries. Staff intervened & [and] they were both redirected. . . ." - Review of Resident #5's medical record occurred on all days of survey. A nurse's note, dated 05/06/23, stated, ". . . Res. continues to walk into other residents [sic] rooms. She was slapped in the face by another resident today in the evening for wanting to take her walker. No injuries. They were both redirected. . . ." When asked for an investigation related to the above incident, the facility provided no further information. On the afternoon of 05/23/23, the administrator (#2) provided a document to the survey staff	F 607	06/22/2023 or prior to next scheduled shift. Facility investigative team (Nurse leadership, administrator, and social services designee) will be re-educated by GSS Regional Clinical Services Director on GSS Incident Reporting / Investigation responsibilities on 06/16/2023. 4. QAPI Coordinator will audit risk management incident reports for completed investigation and proper reporting. Audits will be completed on all incidents 1X /week for 2 weeks, then 10 incidents every other week for 2 weeks, then 10 of incidents 1 X / month for 2 months, then quarterly X1. Any deficiency practice identified will be immediately reported to the administrator. All audit results will be submitted to the QAPI Committee for review and further recommendations. 5. Compliance Date: 06/23/2023	

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F 607	Continued From page 24 which stated, ". . . Call Administrator For . . . Allegation of abuse and neglect . . ." The administrator stated this notice, posted at the nurses' station, is accessible to staff. She confirmed she did not have an investigation for the resident-to-resident incident.	F 607		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		6/23/23

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F 623	Continued From page 25	F 623		

be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 26 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 07/07/22. Based on record review and staff interview, the facility failed to provide the resident's representative and/or the State Long Term Care (LTC) Ombudsman a written notice of transfer for 1 of 2 residents (Resident #18) with a recent hospital transfer. Failure to provide a written copy of the transfer notice does not allow the resident and/or their representative to make an informed decision regarding their rights or inform the	F 623	1. Resident # 18 returned to facility on 05/15/2023. Re-education to clinical leadership team by GSS Regional Clinical Services Director on GSS Notice of Transfer and Discharge Policy and Procedure, the North Dakota specific “Notice of Transfer and Discharge form”, North Dakota “Notice of Transfer and Discharge Q&A” Document, and requirement to provide copy of Notice of Transfer and Discharge form to the ombudsman on 5/31/2023.	

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F 623	Continued From page 27 Ombudsman of the transfer. Findings include: Review of Resident #18's medical record occurred on 05/23/23 and identified a hospital transfer on 05/13/23. The resident's medical record lacked evidence of a transfer notice given to the resident's representative, and/or the ombudsman received a transfer notice. During an interview on 05/23/23 at 4:25 p.m., an administrative staff member (#2) confirmed the facility failed to provide a transfer notice to Resident #18's representative and/or to the ombudsman.	F 623	2. All residents have the potential to be affected by this deficient practice. , 3. Facility developed transfer and discharge packets including ND specific Notice of Transfer and Discharge Form" at nurse's station. The facility clinical leadership team will review PCC Admission / Transfer / Discharge Dashboard each business day and verify Notice of Transfer and Discharge Form has been provided. The Social Services Designee will provide copy of "Notice of Transfer and Discharge" forms to ombudsman. All licensed nurses will be re-educated by the administrator on GSS Notice of Transfer and Discharge Policy and Procedure / Bed Hold Form and process for completion with resident / responsible party for all hospital and therapeutic leaves on 6/22/2023 or prior to next scheduled shift. 4. Administrator or designee will audit residents with hospital and therapeutic leave to verify ND specific Notice of Transfer and Discharge Form was issued and signed copy scanned into OnBase as per policy and regulation. 100% of hospital / therapeutic leaves will be audited 1 X / week for 2 weeks, then 50%	

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F 623	Continued From page 28	F 623	of hospital / therapeutic leaves will be audited every other week X 2, then 25% of hospital / therapeutic leaves will be audited 1 X / month for 2 months, then quarterly X 1 . Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendation. 5. Compliance Date: 06/23/2023	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At	F 625		6/23/23

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F 625	Continued From page 29 the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 07/07/22. Based on record review and staff interview, the facility failed to provide a bed-hold notice to 1 of 2 residents (Resident #18) with a hospital transfer. Failure to provide the facility's bed-hold notice does not allow residents or their legal representatives to make informed choices regarding their readmission rights. Findings include: Review of Resident #18's medical record occurred on 05/23/23 and identified a transfer to the hospital on 05/13/23. The record lacked evidence the facility provided a bed hold notice to the resident and/or their representative. During an interview on 05/23/23 at 4:25 p.m., an administrative staff member (#2) confirmed Resident #18's medical record lacked a bed hold notice.	F 625	1. Resident # 18 returned to facility on 05/15/2023. The bed was held for Resident #18. Re-education to clinical leadership team on GSS Bed Hold Policy and Procedure, to include bed hold form was provided on 5/22/2023 by CLDS (Clinical Learning and Development Specialist). 2. All residents have the potential to be affected by this deficient practice. 3. Facility developed bed hold form / facility leave packets at nurse's station. Facility clinical leadership team will review PCC Admission / Transfer / Discharge Dashboard each business day and verify issuance of bed hold when indicated. All licensed nurses will be re-educated by the administrator on GSS Bed Hold Policy and Procedure / Bed Hold Form and process for completion with resident / responsible party for all hospital and therapeutic leaves on 6/22/2023 or prior to next scheduled shift.	

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F 625	Continued From page 30	F 625	4. Administrator will audit residents with hospital and therapeutic leave to verify bed hold was issued as per policy and regulation. 100% of hospital / therapeutic leaves will be audited 1 X / week for 2 weeks, then 50% of hospital / therapeutic leaves will be audited every other week for 2 weeks, then 25% of hospital / therapeutic leaves will be audited 1 X / month for 2 months, then quarterly X 1. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendation. 5. Compliance Date: 06/23/2023	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, information received from the complainant, and staff interview, the facility failed to follow professional standards of practice for 2 of 10 sampled residents (Resident #2 and #10) and 1 supplemental resident (Resident #16). Failure to	F 658	1. Resident # 16 Fentanyl Patch was discontinued. Medication aide competency verification / re-education provided to medication aide.	6/23/23

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F 658	Continued From page 31 administer medication according to physician orders, and complete a nursing assessment prior to allowing a medication assistant (MA) administer an as needed (PRN) medication (Resident #10); and failure to ensure Resident (#2) consumed her medication may result in a medication error, ineffective management of a resident's condition, and adverse outcomes for the resident. Findings include: Information provided by the complainant indicated nursing staff did not administer Resident #16's Fentanyl patch when it was due to be changed in April 2023. Review of the facility policy titled "Medication: Administration" occurred on 05/24/23. This policy, dated 03/29/23, stated, ". . . The resident has the right to self-administer medications if the interdisciplinary team determines that this practice is safe for the individual resident and is documented in the care plan. An order from the provider is required for this activity. . . . When the location uses medication aides, the delegating nurse is accountable for assessing a situation and making the final decision to delegate. Prior to delegating medication administration: The nurse assesses the resident's nursing care needs. . . ." Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, states, ". . . Carrying Out a Physician's Order . . . If the order is neither ambiguous nor apparently erroneous, the nurse	F 658	2. All residents have the potential to be affected by this deficient practice. 3. All licensed nurses and medication aide will be re-educated by Administrator or designee on GSS Medication Administration Policy and Procedure specific to assessment of resident by licensed nurse prior to prn medication administration by medication aide with follow up evaluation for effectiveness and responsibility of observing medication consumption and following the "6 rights" of medication administration including right time by 06/22/2023 or prior to next scheduled shift. 4. DNS or designee will observe medication pass on 5 random residents and 5 PRN medication administration documentation. Audits will be completed 1 X / week for 2 weeks, then every other week for 2 weeks, then 1 X / month for 2 months, then quarterly X 1. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendations. 5. Compliance Date: 6/23/2023	

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F 658	Continued From page 32 is responsible for carrying it out. . . ." Observation on 05/16/23 at 12:08 p.m. showed a plastic cup half full of a dark red liquid on Resident #2's bedside. The resident stated, "That's cough syrup the staff gave me earlier this morning, I'm going to take it shortly." - Review of Resident #2's medical record occurred on all days of survey. The medical record lacked a physician's order to self-administer medications. During an interview on 05/17/23 at 3:43 p.m., an administrative nurse (#16) confirmed Resident #2 does not have an order to self-administer medications, has not been assessed to self-administer medications and staff should not leave medication on the bedside table. - Review of Resident #10's medical record occurred on all days of survey and included a physician's order for guaifenesin [cough syrup] Give 10 ml [milliliters] by mouth as needed for cough at night time only. During an observation on 05/16/23 at 12:33 p.m., Resident #10 requested her inhaler from a MA (#15). The MA stated, "What is the matter are you having trouble breathing?" The resident stated, "Yes". The MA then stated to the resident, "I don't think you have a PRN inhaler, let me check." After a couple minutes the MA returned to the resident and stated, "You do not have an order for your inhaler PRN, but here is some cough syrup for you. That should help." During an interview on 05/17/23 at 2:19 p.m.,	F 658		

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F 658	Continued From page 33 when questioned about giving Resident #10 cough syrup for complaints of trouble breathing, the MA (#15) stated, "The nurse delegated to me to give her cough syrup because she has a lot of mucous and that's why she has trouble breathing." When asked if the nurse had completed an assessment prior to administering the cough syrup the MA stated she was unaware if the nurse did an assessment or not. During an interview on 05/17/23 at 3:00 p.m., a staff nurse (#11) stated, "She [MA #15] did not tell me about it until after she had already given her the cough syrup." Resident #10's electronic medication administration record showed the resident received guaifenesin cough syrup on 05/11/23 at 8:34 a.m. and 05/16/23 at 12:40 p.m., not at bedtime only per the physician order. - Review of Resident #16's medical record occurred on all days of survey and included a physician's order for a Fentanyl patch (a narcotic pain medication) 25 micrograms/hour, change every 72 hours. Review of Resident #16's April 2023 Medication Administration Record (MAR) lacked documentation staff applied a new patch every three days as ordered on one occasion. During an interview on 05/23/23 at 4:25 p.m., an administrative nurse (#2) confirmed Resident #16 did not have a Fentanyl patch in place for three days, as it was unavailable from the pharmacy.	F 658		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		6/23/23

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F 689	Continued From page 34 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, information received from the complainant, record review, and resident and staff interview, the facility failed to ensure an environment free of accident hazards for 1 of 1 coffee/hot water machine in the dining room. Failure to ensure appropriate coffee/water temperatures resulted in serving temperatures above the acceptable range and may result in serious burns/injuries to residents. During the on-site complaint survey, the team determined an Immediate Jeopardy (IJ) situation existed on 05/17/23 at 3:34 p.m. The IJ resulted from temperature readings obtained from the coffee/hot water machine, a lack of temperature monitoring by staff, and an injury to a resident. This finding placed residents in immediate danger due to hot temperatures and the potential for serious burns. * 05/17/23 at 4:45 p.m. The survey team notified the administrator and director of nursing of the IJ and requested they develop a plan for removal of the immediate jeopardy. * 05/18/23 at 3:41 p.m. The survey team reviewed and accepted the facility's removal plan for the IJ.	F 689	1. Immediate actions were taken by administrator on 5/17/2023: On 5/17/2023 at 5:45pm, coffee maker removed from service. Signage posted “not available for use”, lock out tag out completed, and coffee maker unplugged. Signage posted to “temp coffee prior to serving and allow to cool until 155F or below”. Created list of residents who are care planned to have lids with hot beverages and posted in the kitchen and educated staff. Administrator started education 5/17/2023 at 10:10pm On 5/18/2023, at 8:30am, Smuckers, coffee machine company, came to facility to service the coffee machine and turned down internal temp. Alternative coffee maker is in kitchen and is being temped and logged before every meal and at resident request. Staff will temp coffee maker for 3 days to monitor if temp is at policy serving temp. If logged coffee temps are within correct range by policy for 3 consecutive days, the Administrator	

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F 689	Continued From page 35 * 05/23/23 at 5:55 p.m. The team notified the administrator of the IJ removal. (can you say this) *On 05/23/23, the survey team verified the implementation of the removal plan and the IJ removal on 05/18/23. The deficient practice remained at an "E" scope and severity following the removal of the immediate jeopardy. Findings include: Information received from the complainant identified concerns with the temperatures of food/drink served in the dining room, and a resident sustaining a burn due to hot coffee. Observation in the main dining room occurred on 05/16/23 at 11:52 a.m. A staff member brought a cup of hot water and a lid to Resident #17 and made tea. The staff member placed the lid on the table instead of putting it on the resident's cup. Another resident stated to her tablemate, "Be careful, it's hot [referring to her cup of tea]. Mine is really hot." -Review of Resident #17's care plan occurred on 05/16/23 and identified, ". . . HOT BEVERAGE AND SOUP SAFETY: Assist/supervise resident with all hot beverages by providing safety cup for coffee at meals . . ." On the afternoon of 05/16/23, the survey team measured the temperature of the coffee, which read 169 degrees Fahrenheit (F). The hot water temperature measured 167.8 degrees F. - Review of Resident #16's medical record	F 689	will evaluate safe use for residents. Education provided to nursing staff on reporting accidents relating to burns, completing appropriate assessments and initiating incident reports. Administrator started education 5/17/2023 at 10:10pm. Resident # 16 has had weekly skin observation completed with no skin issues identified. Resident # 16 care plan updated to include focus, goal, and interventions for managing hot beverages safely. 2. All residents have the potential to be affected by this deficient practice. , 3. All residents are evaluated on admission, re-admission and change of condition for their ability to safely manage hot liquids. Care plan focus, goal and interventions are initiated and updated as indicated. DFN (Director of Food and Nutrition) or designee will temp coffee from coffee maker twice daily and record. If temp exceeds correct range, DFN will report to administrator and maintenance supervisor and coffee will not be served until at a safe temperature. All staff will be re-educated by the administrator on the responsibility of preventing accidents and incidents / ensuring resident safety,	

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F 689	Continued From page 36 occurred on 05/17/23. A nurse's note, dated 04/30/23 at 9:15 a.m. stated, " . . . LATE ENTRY . . . observe wet coffee stain on resident shirt. skin directly under stain mid chest area red blanchable skin intact no blisters or abnormalities noted at this time. resident states she spilled some coffee but it does not hurt. NP [nurse practitioner] updated via fax . . ." The resident's record lacked further follow-up/assessment related to this incident. On 05/17/23 at 2:58 p.m., a dietary services staff member (#1) stated she measured the temperature of the coffee and it read 178 degrees F. The staff member stated, "That's way too hot. It should never be that hot." She stated the temperature should not be above 160 degrees F and confirmed dietary staff do not measure the temperature of the coffee/hot water. During an interview on the afternoon of 05/16/23, an administrative staff member (#2) stated she would expect staff to report and investigate a coffee burn incident.	F 689	specific to the GSS Hot Liquid Safety Policy and Procedure on 06/22/2023 or prior to next scheduled shift. 4. Administrator will audit the 'twice a day coffee temperature log" verifying documented temperature and actual temp of coffee from coffee maker. Audits will be completed 2 X / week for 2 weeks, then every other week for 2 weeks, then 1 X / month for 2 months, then quarterly X 1. DNS will audit 5 random resident's charts for identified risk with hot beverages; for care plan focus, goal and interventions if indication; and observation audits of serving hot beverage to verify care is provided as per care plan. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendation. 5. Compliance Date: 06/23/2023	
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	F 725		6/23/23

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F 725	Continued From page 37 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 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 information provided by complainant, observation, and staff and resident interviews, the facility failed to provide sufficient nursing staff and related services to meet the residents' needs for 3 of 10 sampled residents (Resident #1, #3, and #9) and 3 of 6 confidential residents (Resident C, D and F). Failure to provide sufficient staffing may result in residents experiencing falls, poor hygiene, incontinence, and skin issues and may negatively affect the residents' physical, mental, and psychosocial well-being. Findings include: Information provided by the complainant	F 725	1. Call light response time report was reviewed, and resident care assignments adjusted to allow staff to respond to residents needs timelier. The ability to shut off call light from nurses' station was deactivated. 2. All residents have the potential to be affected by this deficient practice. 3. All staff will be re-educated by administrator or designee by 06/22/2023	

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F 725	Continued From page 38 identified concerns with extended call light response times, which resulted in incontinent episodes. Review of the facility policy titled "Call Light" occurred on 05/24/23. This policy, dated 10/21/22, stated, ". . . To promptly answer resident's call light. 2. When resident's call light is observed/heard, go to resident's room promptly. 3. Respond to request as soon as possible. . . ." During interviews, when asked about sufficient staff/response to call lights, residents and family members made the following statements: * 05/16/23 at 12:05 p.m., Resident C stated, "If you need something, don't expect it to happen anytime soon. If you put your call light on it takes 45-60 minutes before they answer it." * 05/16/23 at 3:11 p.m., Resident #9 stated, "Sometimes I have to wait 20-30 minutes when I put my call light on. It bothers me because these other residents could hit me by then or taken or broke my things. Call lights not being answered is the worst when I'm sitting on the toilet and it takes them that long, because my feet go numb. Sometimes I stand up, try to wipe, and try to pull my brief up. But I'm afraid I will fall. I don't know why it takes them that long when they know they just put you on the toilet." * 05/16/23 at 5:05 p.m., Resident #1 stated staff take a long time to answer call lights, sometimes longer than 30 minutes. The resident stated she has had to wait 50 minutes for help to get into her wheelchair, almost two hours for a pain medication, and 20 minutes for assistance off the toilet. She also voiced concerns with staff turning off call lights and not providing assistance. * 05/17/23 at 8:05 a.m., Resident #3 stated,	F 725	or prior to next scheduled shift on GSS Call Light Policy and Procedure specific to all staff can answer call lights and facility goal is all call lights answered in a timely manner. Facility will implement use of walkie talkie for staff communication to meet resident needs in a timelier manner. 4. Administrator or designee will interview 5 residents on timeliness of cares and review call light response time report. Audits will be completed 1 X / week for 2 weeks, then every other week for 2 weeks, then 1 X / month for 2 months, then quarterly X 1. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendations. 5. Compliance Date: 6/23/2023	

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F 725	Continued From page 39 "They [the facility] are short staffed. It's getting bad," and call light wait times are "a half hour to 45 minutes, half hour minimum at times." She further stated, "If you need something, don't count on staff coming to help." * 05/17/23 at 8:10 a.m., Resident F stated, "If I need their help, which isn't very often, it takes them usually 30 minutes to answer it [the call light]." * 05/17/23 at 2:00 p.m., Resident D stated, "It takes them [the staff] half an hour or an hour usually to answer my call light and most of the time they do not even come in, they just turn my light off at the desk." Review of resident group meeting minutes from December 2022 through May 2023 showed the following: * 12/01/22: ". . . Lights are being shut off at the desk and nobody coming to the rooms . . ." * 03/02/23: ". . . Lights are not being answered, staff are turning them off at the desk . . ." Observation on 05/16/23 3:06 p.m. showed the call light in room 306 activated and at 3:09 p.m. the call light deactivated. Observation showed no one entered room 306. During an interview on 05/24/23 at 12:24 p.m., an administrative staff member (#18) stated staff should not be turning the residents call light off at the nurses' station, and she expects staff to answer a residents call light as soon as possible.	F 725		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with	F 726		6/23/23

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F 726	Continued From page 40 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure competent staff for 11 of 11 contract personnel files reviewed (Staff #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 and #13). Failure to provide facility orientation may result in a lack of knowledge related to facility procedures, competencies and skill sets needed to care for residents and increase the risk of physical or	F 726	1. Upon discovery, facility implemented agency staff onboard training utilizing “Contingent CNA & Other Contingent Staff Orientation” and “Contingent Nurse Orientation” with “Abuse, Neglect Prevention/Mandated Reporting / Reporting of Suspected Crime” with facility procedure. All current agency /	

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F 726	Continued From page 41 psychological harm to the residents through improper care. Findings include: On 05/23/23, the survey team requested information regarding orientation of travel/contract staff for seven travel nurses, and four travel certified nurse aides (CNAs). Review of the facility's orientation files for travel/contract staff identified the facility failed to provide orientation to the travel/contract staff (#3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13). During an interview on 05/24/23 at 12:39 p.m., an administrative nurse (#1) confirmed the facility failed to complete orientation with all of their travel/contract staff. Failure to provide orientation increased the potential for lack of appropriate care, services, and monitoring of residents consistent with their individualized plan of care.	F 726	contingent staff trained. 2. All residents have the potential to be affected by this deficient practice. 3. Administrator, department heads, and scheduler re-educated on agency onboarding requirements by Regional Clinical Services Director on 5/23/2023. 4. Administrator or designee will review all agency / contingent staff onboarding orientation checklists to verify training is completed. Audits will be completed 1 X / week for 2 weeks, then every other week X 2 weeks, then 1 X / month for 2 months, then quarterly X1. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendations. 5. Compliance Date: 6/23/2023	
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at	F 727		6/23/23

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F 727	Continued From page 42 least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of nurse staffing schedules, and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day, seven days a week, for ten days of the 58-day period reviewed (03/25/23 to 05/21/23). Failure to ensure sufficient, qualified nursing staff are available 8 consecutive hours a day has the potential to affect the health and safety of all the residents residing in the facility. Findings Include: On 05/23/23, the facility provided a copy of the nurse staffing schedules for the period of March 25 - May 21, 2023. A review of the schedules showed the facility failed to have the required RN coverage on 03/25/23, 04/08/23, 04/15/23, 04/16/23, 04/29/23, 04/30/23, 05/06/23, 05/07/23, 05/20/23 and 05/21/23. During an interview on 05/24/23 at 1:03 p.m., an administrative staff member (#1) confirmed the facility lacked RN coverage and stated the facility only has two staff RNs and one contracted RN.	F 727	1. Facility contracted with 2 agency RNs, allowing facility to comply with 8 hour / day, 7 days / week RN coverage effective 5/30/2023 2. All residents have the potential to be affected by this deficient practice. , 3. Facility continues to advertise for open RN positions. Re-education to the Administrator, nurse leadership and scheduler on RN staff requirements by GSS Regional Clinical Services Director. Facility will adjust working schedule to accurately reflect when administrative nurses are providing the RN coverage. 4. Administrator or designee will audit nursing schedules for 8 hour / day RN	

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F 727	Continued From page 43	F 727	coverage 7 days / week. Audit will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months, then quarterly X1. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendation. 5. Compliance Date: 06/23/2023	
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, information received from the complainants, record review, review of facility policy, and staff interview, the facility failed to provide appropriate dementia care and services for 2 of 3 sampled residents (Resident #5 and #8) with a diagnosis of dementia. Failure to adequately assess and monitor behaviors and implement effective behavior management interventions resulted in a decreased level of psychosocial well-being for Resident #5 and Resident #8 as well as other residents affected by their behaviors. Findings include: Review of the facility policy titled "Dementia Care	F 744	1. Residents # 5 and #8 behaviors were reviewed at Behavior Committee with care plan intervention updates 2. All residents with dementia have the potential to be affected by this deficient practice. 3. All staff will be re-educated by administrator or designee on Dementia Care specific to approach, communication and re-direction of residents. All nursing	6/23/23

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F 744	Continued From page 44 Guidelines" occurred on 05/24/23. This policy, dated 02/17/22, stated, ". . . All behavior has meaning and is a means to communicate an unmet need. It is important to gather as much information related to the behavior as necessary to determine why a behavior is occurring. A resident's distress may be related to a variety of factors, including physical needs, emotional needs, the environment or actions of the caregiver. . . . Utilize individualized, non-pharmacological approaches for behaviors since there is no magic pill to eliminate behaviors. Remember that what works on one day may not work another day. . ." Review of the facility policy titled "Behavioral Causes and Interventions" occurred on 05/24/23. This policy, dated 01/31/23, stated, ". . . When a nursing home accepts a resident for admission, the facility assumes the responsibility of ensuring the safety and well-being of the resident. It is the facility's responsibility to ensure all staff are trained and are knowledgeable in how to react and respond appropriately to resident behavior. . . . A resident's behavior may be related to a variety of factors. Use an interdisciplinary team approach to determine probable causes of the behavior and understand the meaning behind the behavior. . . ." Review of the facility policy titled "Care Plan" occurred on 05/24/23. This policy, dated 09/22/22, stated, ". . . Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized, person-centered, comprehensive	F 744	staff will be re-educated on providing resident centered non-medication interventions with documentation by 06/22/2023 or prior to the next schedule shift. System change: all residents with Dementia exhibiting moods and behaviors or receiving antipsychotic medications will have scheduled documentation for non-medication interventions and response. 4. DNS or designee will audit the care plans for residents with Dementia with behaviors to ensure care plans include resident centered non-medication interventions, will audit POC documentation for moods / behaviors with interventions and nursing TAR documentation. All residents who had a care conference the prior week will be audited 1 X / week for 2 weeks, then a random sample of 5 residents will be audited every other week X 2 weeks, then a random sample of 5 residents will be audited 1 X / month for 2 months, then quarterly X1. Any deficient practices identified will be addressed immediately, with any action taken documented on audit form. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendation. 5. Compliance Date: 6/23/2023	

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plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. . . . The plan of care will be modified to reflect the care currently required/provided for the resident. The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. . . . Care plans will also be reviewed, evaluated, and updated when there is a significant change in the resident's condition . . ."

Information received from the complainants identified concerns related to Resident #5 and Resident #8's aggressive and/or wandering behaviors.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance, Alzheimer's disease, and restlessness and agitation. Current physician's orders included Haldol (an antipsychotic) 2.5 milligrams (mg) intramuscular (IM) every four hours as needed (PRN) (started on 05/03/23) for severe agitation related to dementia and Zyprexa (an antipsychotic) 5 mg orally (PO) every 24 hours PRN (started on 05/01/23) for agitation related to "restlessness and agitation." Additional physician's orders included twice daily monitoring for mood and behaviors, initiated on 05/05/23.

Resident #5's current care plan stated, ". . . Focus . . . The resident is on antipsychotic medication therapy R/T [related to] Dementia . . . Interventions . . . Attempt non-pharmacological

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interventions: 1:1 [one to one] visit, offer to go for a walk, listens to music . . . Date Initiated 04/13/2023 . . . Focus . . . The resident is on antidepressant medication therapy R/T depression/anxiety . . . Interventions . . . Nonpharmacological interventions: offer baby doll, listen to music, 1:1 visit . . . Date Initiated: 04/13/2023 . . . Focus . . . The resident has a mood problem R/T tearfulness, upset, emotional distress . . . Interventions . . . Attempt non-pharmacological interventions: sit 1:1 with resident, offer baby doll, look at pictures of kids . . . Date Initiated: 04/13/2023 . . . Focus . . . The resident has a behavior symptom R/T Dementia E/B [evidenced by] wandering at times, throwing objections [sic], aggressive with staff, sleeping in other resident's beds, strikes out at staff/residents, barricades her door with herself, threatens staff with sharp objects, yelling/crying . . . Interventions . . . Resident prefers the following diversional activities: offer baby doll, enjoys sitting by windows, 1:1 visits, reading her poems, enjoys pictures of kids, offer hydration and snacks . . . Date Initiated 05/02/2023 . . . Revision on: 05/02/2023 . . ."

Resident #5's nurses' notes identified the following:
*03/31/23 at 3:12 p.m.: ". . . Resident became aggressive with staff. Resident was offered PRN medication and refused. Afterwards she began throwing her water and splashing it at staff. She became increasingly aggressive. Staff attempted to clean water up and resident threw her water cup at staff. Resident then blocked door by standing behind it to prevent staff from entering. Resident did move and exit her room allowing staff to clean up the water. When resident exited

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room she began to wander into other resident rooms. When redirected she became aggressive and was hitting staff. Resident was separated from others and 1:1 was initiated. . . ."
*04/07/23 at 8:53 a.m.: ". . . IDT [interdisciplinary team] reviewed residents [sic] potential fall. Resident has history of sitting self on floor, and often sits there by choice. Resident was wearing grippy socks. Resident has advanced dementia. She is able to ambulate independently. Resident likes constant reassurance. Care plan for body pillow when in bed. Resident likes to snuggle her doll and she may sleep better if she feels more secure. . . ."
*04/09/23 at 2:43 a.m.: ". . . Res. [resident] continues to get up & [and] walk into other residents rooms on NOC's [nights]. She continues to show s/sx [signs and symptoms] of emotional distress. She weeps on nights. Nursing staff reported to this writer the res. was found in another female's bedroom. She was redirected back to her room & encouraged to get some rest. Dolls placed in bed c [with] res. for comfort. She was given PRN Lorazepam [anti-anxiety medication] twice on this shift & its been non - effective. . . . ."
*04/10/23 at 12:22 a.m.: ". . . Res. continues to get up & walk into other residents rooms on NOC's. She continues to show s/sx of emotional distress. She weeps on nights. She was redirected back to her room & encouraged to get some rest. Dolls placed in bed c res. for comfort. She was given PRN Lorazepam on this shift & its been non - effective. . . ."
*04/11/23 at 1:42 p.m.: ". . . Res. is currently exhibiting behaviors of constantly crying, hanging on to the CNA [certified nurse aide] and then crying frantically when CNA went into the

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F 744	Continued From page 48 bathroom. . . ." *04/12/23 at 7:00 p.m.: ". . . LATE ENTRY . . . Floor nurse spoke with on call ER [emergency room] provider [name] in regards to resident agitation and being combative towards staff. New orders obtained for One time only Lorazepam 2 mg IM for agitation. . . ." *04/12/23 at 7:20 p.m.: ". . . LATE ENTRY . . . Floor nurse called to [another resident] room. Resident [#5] was in room w/ [with] door closed and refused to open door with body weight holding it closed while yelling word salad [an unintelligible mixture of seemingly random words]. Floor nurse attempted to speak with resident through the door resident would open the door to swing her fist at this nurse. Once resident opened the door resident came towards the nurse pushing nurse while grabbing and squeezing wrists. Floor nurse attempted to break free resident attempted to swing her hands at this nurses face while using her other hand to grab onto floor nurse scrub top. Floor nurse and staff attempted to re-direct by using dolls, teddy bear, talking softly which was unsuccessful. Staff member able to assist nurse with removing resident hands from scrubs. Resident then turned to follow nurse down the hallway. Floor nurse gave a task to attempt to remove other residents out of the area away from resident. Resident continued to be combative towards staff member. Floor nurse called family for consent . . . After failed attempts of interventions, floor nurse contacted on call ER provider . . ." 04/13/23 at 2:42 p.m.: ". . . Resident is restless and sobbing. She has grabbed staff and refused to let go while attempting to hit them in the face with clinched fists. Resident is difficult to re-direct even with the use of her dolls. Attempts are being	F 744		

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made to keep her in quieter environment and away from other residents, this is difficult as she wanders and seeks others with clinched fists. Resident did accept fluids. Currently sitting with NHA [nursing home administrator] as a 1:1. Call has been placed to MD [medical doctor] clinic to request a change in medications. . . ."
*04/13/23 at 10:09 a.m.: ". . . DON [director of nursing] reviewed behavior and psychotropic use prior to admit. Dtr [daughter] reports that resident had never struck anyone prior to admit. She had thrown her beverages at people in the past. Resident had been on Rispiradal [sic] [an antipsychotic] and was switched to Seroquel [an antipsychotic] for a week and a half and her behaviors of yelling and crying worsened on the Seroquel, so it was d/c'd [discontinued] and she was put back on Risperdal. Residents Risperadal [sic] has been discontinued at facility. Notified dtr that on 4-12-23 resident was physically aggressive to staff members by grabbing their clothing and not releasing them from her grip. She also squeezed their arms and struck them in their faces. This was observed by our other residents and they are fearful of her. Notified dtr of both falls that occurred on 4-12-23 w/o [without] injury. MD had been notified of falls and will be updated today about her aggressive behaviors directed at others. . . ."
*04/13/23 at 3:31 p.m.: ". . . [provider name] Increase Risperidone to 0.5 mg PO BID [twice a day]. Zyprexa [an antipsychotic] 5 mg IM x1 [one time], may repeat after 2 hours PRN . . ."
*04/14/23 at 4:55 a.m.: ". . . Res. continues to walk into other rooms t/o [throughout] the night. No combative behaviors noted on this shift to time. Res. is reluctant to cares & is difficult to redirect & console most of the time. . . ."

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F 744	Continued From page 50 *04/17/23 at 11:05 p.m.: ". . . Upon this writer's arrival to unit it was reported that res. was in the dinning [sic] room hitting staff & grabbed a knife. Res. was blocked from injuring staff & other residents. She was not easily redirected & appeared distressed. She was taken to her room while she was holding her baby which provided some relief/comfort. While she was in the room she appeared calmer but as soon as staff got close she charged & became combative. She was given a PRN to help stabilize her mood. She got up & went to living room space & was walking around. No further attempts to hit staff/residents reported at this time. Nursing staff does report word salad communication rooted in feeling abandoned. You 'left' , 'where did go?' 'I waited.' . . ." *04/18/2023 at 6:46 p.m.: ". . . This AM [Resident #5] was very agitated and upset. She walked up to the Nurse and began to punch her in the arm. In the course of a 1/2 hr. she did this 3 times. The rest of the day there were no further reports of any behaviors. . . ." *04/19/2023 at 10:49 p.m.: ". . . resident aggressive with staff hitting, throwing things, charging at staff, yelling, staff tried to redirect resident with no effect, Prn zyprexa injection given . . ." *04/22/23 at 5:45 p.m.: ". . . Resident agitated today crying, staff unable to redirect resident walking in other residents rooms. Zyprexa IM given at 1200 [noon] and was effective for approx [approximately] 3 hours 2nd IM Zyprexa given at 1530 [3:30 p.m.] and was effective as resident in her room lying in bed with eyes open . . ." *04/23/23 at 10:41 p.m.: ". . . Res. was om [sic] her room & became combative at HS [bedtime]. She was unable to be redirected or comforted by	F 744		

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nursing staff. She was swinging/punching & attempted to lift w/c [wheelchair]. 1 dose of PRN given -- effectiveness is unknown at this time. She is in tv room area showing s/sx of emotional distress (she walked out of her room into this space) after PRN was given & this writer sat c her for approx 15 mins [minutes] to attempt to console her distress. Res. continues to use unintelligible speech to communicate . . ."
*04/25/23 at 4:48 p.m.: ". . . Resident had some agitation today and was running and crying, going in/out of others rooms. Resident came into contact with another resident and hit that resident in the chest. No injuries sustained, but per protocol families are notified . . ."
*04/26/23 at 1:44 p.m.: ". . . New orders received from [medical provider] as follows: 1. increase Olanzapine [Zyprexa] to 10 mg po q [every] HS 2. decrease escitalopram [an antidepressant] to 10 mg po daily x5 days, then 5 mg po daily x5 days, then stop 3. start fluoxetine [an antidepressant] 10 mg po q AM. Ok to start now and overlap with #2 . . ."
*04/27/23 at 12:05 p.m.: ". . . Due to aggressive behaviors towards others recommend transfer to ER for geriatric psych in pt. [patient] admission. If seems to be doing better after med changes yesterday please let me know. writer called clinic spoke with nurse [name] updating resident had no reports of behaviors thru the night and to current. resident is resting quietly in bed eyes closed at this time. nurse [name] gave verbal update to MD. MD with new verbal orders: if behaviors occur again keep order for prn. MAR [medication administration record] updated. . . ."
*04/28/23 at 6:38 p.m.: ". . . Res. has become aggressive on shift. Will send to ED [emergency department] per MD direction. . . ."

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F 744	Continued From page 52 *04/29/23 at 12:56 a.m.: ". . . Received order from primary provider to send out resident for aggressive behaviors towards others. Resident had 3 episodes of aggression on this shift. She was swinging & punching staff/others. Res. was transferred out via ambulance & officer was present as well. NP [nurse practitioner] called & reported there might be an open bed for her in another hospital tomorrow. NP reported she had no behaviors while in the hospital. Res. returned via ambulance; no new orders. She was taken to the bathroom & from there made ready for bed. . . ." *04/29/23 at 3:07 p.m.: ". . . Received order from primary provider to send out resident for aggressive behaviors towards others. Resident had several episodes of aggression. She was swinging & punching staff/others, picking up objects and trying to swing them at staff. Ambulance assistance called. . . ." *04/29/23 at 5:48 p.m.: ". . . Resident returned from ER per facility transport van. New script for Haloperidol lactate [an antipsychotic] injection 5mg IM inj. [inject] q 8 hours PRN for agitation. ER also sent 3 doses with resident due to pharmacy being closed. ER physician stated the have calls out for bed availability in geriatric psychiatry and they will notify our facility when a bed is available. He also advised that EMS [emergency medical services] will be unable to transport resident to an out of town facility and we would have to provide our own transportation. . . ." *04/30/23 at 12:04 a.m.: ". . . Res. had ED visit and was given medication to stabilize aggression on day shift. She was quiet on evening shift & was sitting in the dinning [sic] room upon this writers arrival. Wondering [sic]/pacing on	F 744		

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evening. At approx. HS a resident [room number] approached this writer to inform them that res. was sleeping in her bed. This resident was visibly upset. A nurse & CNA went to her room & confirmed [Resident #5] in her bed. She was unable to woken [sic] up. Eventually she was arousable & was transferred from bed to w/c. Nursing staff was able to dress her since she was not wearing pants. On the way out res. fell asleep on w/c & while being moved from room into hallway she fell on her knees c her face towards the hallway. . . . Did not acquire at [sic] injuries. . . .".

*05/01/2023 at 10:12 a.m.: ". . . Spoke with [provider name] in ER regarding [Resident #5]. He was very interested in helping us. He gave the following orders: Olanzipine [sic] po 15 mg qd [daily]. Olanzipine [sic] po 5 mg prn q 24 hours. Ativan 2 mg IM PRN BID. He states to leave the injectable Haldol order in place for now so that we will have another tool at our disposal if it is needed. He wants me to call him on Wednesday to let him know how these interventions have affected her. He states that ER does not find psych placement for geriatric (nursing home) residents, and that is something that is up to the facility. Administrator and DON notified of this. . . ."

*05/01/23 at 9:04 p.m.: ". . . Ativan 2 mg IM PRN given dt [due to] restlessness & aggression. Res. did allow 2 nursing staff members to sit c her but she became restless & combative. IM given to deltoid on the R) arm at approx. 2030 [8:30 p.m.]. Currently monitoring for effectiveness. . . .'

*05/03/23 at 1:07 p.m.: ". . . Records were sent to [facility] for a Geri-psych [geriatric psychiatry] bed. . . ."

*05/03/23 at 1:14 p.m.: ". . . Resident was seen

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F 744	Continued From page 54 on rounds this AM by [medical director] with the following order changes: 1. Stop IM Ativan order 2. Decrease Haloperidol lactate to 2.5 mg q 4 hr prn for severe agitation . . ." *05/06/23 at 2:10 a.m.: ". . . Res. continues to walk into other residents rooms. She was slapped in the face by another resident today in the evening for wanting to take her walker. No injuries. They were both redirected. Ns [nursing] sat c [Resident #5]. She was weepy for a little while but was comforted c visiting & holding hands. Ns & res. sat while she colored & drew. She appears to enjoy tactile activities. She responses [sic] well to 'feel' & touch. She likes touching pencils, dolls, drawing lines. . . ." *05/11/23 at 5:49 p.m.: ". . . Resident has been pacing, exit seeking and muttering angrily under her breath. Currently able to redirect . . ." *05/12/23 at 11:01 p.m.: ". . . resident pacing in hallway following staff, going into residents room, able to be redirected out of rooms, offered resident snack, resident laying in bed resting at this time . . ." *05/14/23 at 12:36 a.m.: ". . . resident was pacing halls and going into other residents room, had bouts of crying and being agitated with staff, able to redirect, in bed resting . . ." *05/15/23 at 4:32 a.m.: ". . . resident was having increased agitation and crying episodes, increased restlessness and pacing gave prn medication at 1900 [7:00 p.m.] was ineffective resident kept having restlessness and anxiety was able to redirect and helped resident into bed around 1000 pm [10:00 p.m.]. . ." *05/16/23 at 12:42 a.m.: ". . . resident has had behaviors until 10 pm, agitation, pacing, charging at staff prn was given at 1800 [6:00 p.m.] with mild effectiveness, resident was no longer	F 744		

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	355093	A. BUILDING _____ B. WING _____	C 05/24/2023

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F 744	Continued From page 55 agitated but was tearfull [sic], and pacing and restlessness . . ." *05/16/23 at 3:00 p.m.: ". . . Resident continues to be agitated. Refused multiple attempts with oral medications. Resident was content in North activity area for some time. She recently became more agitated and was pacing, following residents and pulling on residents belongings. Staff was not able to fully redirect resident, she refused food, drink, bathroom and activity. PRN given for severe agitation. . . ." *05/16/23 at 11:59 p.m.: ". . . resident restless, pacing in halls, resident was able to be redirected, resident received a whirlpool bath and that seemed to relax resident after resident was out of bath resident went and laid in bed, resident is currently in bed with eyes closed . . ." *05/17/23 at 12:34 p.m.: ". . . Resident was seen by [medical director] this AM for focus visit. The following changes were made: 1. increase Fluoxetine to 20 mg q AM 2. Increase Olanzapine to 20 mg q HS 3. Outpatient psych consult . . ." *05/23/23 at 12:05 p.m.: ". . . Resident woke up from nap crying uncontrollably and yelling at staff. Staff attempted redirection, was able to get her dressed and into chair. Resident still upset. . . ." *05/23/23 at 5:38 p.m.: ". . . Resident has been 1:1 with staff since 2pm. She does very well with this. She was content, cooperative, and pleasant looking at picture books and talking to staff. . . ." During the period of 03/31/23 to 05/13/23 (44 days) Resident #5 ' s psychotropic medications were adjusted at least ten times by three different providers before ordering a psychiatric consult. Resident #5's medical record lacked evidence the facility staff implemented individualized	F 744		

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non-pharmacological interventions on a consistent basis, evaluated the effectiveness of the interventions, reviewed/revised existing interventions, and implemented additional interventions as needed.

Review of facility incident reports occurred on 05/24/23. A report, dated 04/25/23, stated, ". . . This resident [Resident #7] was hit with a closed fist to the chest by [Resident #5] while he was doing exercises. . . ." Another report, dated 04/25/23, stated, ". . . Resident [#5] walked into therapy room and grabbed resident [#7] by the shirt and punched resident with a closed fist. . . ."

During an interview on the afternoon of 05/16/23, a staff member (#17) stated Resident #5 has behaviors "almost constantly." "It's crazy, last week she got slapped by another resident. She hits at residents and staff. People are scared of her."

During an interview on 05/17/23 at 10:30 a.m., a social services staff member (#14) stated the facility has had issues related to Resident #5 hitting staff or other residents. She identified a psychiatric provider has not seen Resident #5 since her admission in March 2023, although Resident #5 has seen psychiatry in the past. The staff member also stated she requested the provider order a psychiatric consult on 05/17/23.

The facility failed to assess and monitor patterns and trends of behaviors in an effort to minimize these behaviors, recognize unmet needs, or prevent situations/triggers which may lead to behaviors or physical aggression toward other residents. The facility failed to develop an

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F 744	Continued From page 57	F 744		

effective behavior management program, consistently implement purposeful and meaningful activities in an attempt to manage the behaviors exhibited by Resident #5, evaluate the behavior management program on an on-going basis, and modify interventions as needed. The facility failed to ensure Resident #5 did not infringe upon the rights of others while still allowing her to achieve her highest level of well-being. These failures resulted in physical contact between Resident #5 and other residents and many residents experiencing fear, anxiety, frustration, and anger related to Resident #5's wandering and physically aggressive behaviors.

- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included unspecified dementia, moderate, with anxiety. Current physician's orders included Hydroxyzine HCL 25 mg by mouth every 6 hours as needed for anxiety.

Resident #8's current care plan stated, ". . . Focus . . . The resident has impaired cognitive function/dementia or impaired thought processes R/T dementia E/B confusion . . . Interventions . . . Engage resident in simple, structured activities that avoid overly demanding tasks such as: towel folding . . . Date Initiated: 02/27/2023 . . . Focus . . . The resident is on antipsychotic medication therapy R/T Dementia . . . Interventions . . . Attempt non-pharmacological interventions offer walks, visits, and snacks. . . . Date Initiated: 02/15/2023 . . . Focus . . . The resident has a behavior symptom R/T being resistive to cares, wandering . . .
Interventions . . . Resident prefers the following diversional activities: 1:1 visits or visits with

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family, listening to music . . . Date Initiated: 02/27/2023 . . ."

Resident #8's progress notes included the following:
* 04/22/23 3:09 p.m. ". . . resident was in another resident room, laying in bed the writer woke resident up and asked resident to come to her room and that this was not her room resident became agitated and said it is my room and grabbed this writer arm and twisted and yelled leave me alone, another staff member came to try to redirect resident after several attempts was able to redirect resident back to room, resident was still being combative to staff stepping on feet and swinging at staff . . ."
* 04/25/23 3:29 p.m. ". . . hydrOXYzine HCl Oral Tablet 25 MG Give 25 mg by mouth every 6 hours as needed for anxiety restlessness roaming exit seeking . . ."
* 04/27/23 5:49 p.m. ". . . writer in dinning [sic] room alerted by CNA "[Resident #8] is out" writer ask which door and staff states 400 hall. writer runs to 400 hall door and in route observes staff CNA with resident entering building from side door. resident smiling states 'I was going home' . . ."
* 04/28/23 9:45 a.m. ". . . resident repeatedly attempts to open doors throughout facility and enters other residents rooms. Staff provides redirection, works for a short time. . . ."
* 05/01/23 11:20 p.m. ". . . Resident is refusing cares. Re-approach attempted unsuccessful. . . ."
* 05/12/23 11:04 p.m. ". . . resident pacing more in halls . . ."
* 05/23/23 12:47 p.m. ". . . Resident pacing hallways, entering multiple rooms. Staff attempted redirect multiple times with water,

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F 744	Continued From page 59 food, and activities. Resident refused lunch multiple times. PRN given for anxiety. . . ." Observation on the afternoon of 05/16/23 showed Resident #5 wandering in the hallways carrying a stuffed animal. Another wandering resident (Resident #8) attempted to take the stuffed animal from Resident #5. Resident #5 stated, "No!" and pulled the stuffed animal away when a staff member intervened and redirected the residents back to the commons area. During an observation on the evening of 05/16/23, Resident #8 wandered through the commons area and touched the face and hands of a resident asleep in her wheelchair. Another resident yelled, "Stop that! Don't wake her up!" Observation on 05/23/23 at 12:15 p.m. showed Resident #8 wandering in the hallways carrying several papers. An unidentified staff member redirected the resident to the dining room table. The resident sat at the table for less than one minute, got up, and started wandering in the hallways again. Resident #8's medical record lacked evidence the facility staff implemented individualized non-pharmacological interventions on a consistent basis, evaluated the effectiveness of the interventions, reviewed/revised existing interventions, and implemented additional interventions as needed. Refer to F550, F565, and F600.	F 744		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		6/23/23

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F 758	Continued From page 60 §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 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	F 758		

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F 758	Continued From page 61 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, review of facility policy, and staff interview, the facility failed to ensure residents remained free from unnecessary psychotropic medications for 1 of 1 sampled resident (Resident #5) receiving as needed (PRN) antipsychotic medications. Failure to attempt non-pharmacological interventions prior to administering PRN psychotropic medications and limit PRN psychotropic use to 14 days unless re-evaluated by a practitioner placed the resident at risk of receiving unnecessary medications and experiencing adverse drug effects related to their use. Findings include: Review of the facility policy titled "Psychotropic Medications" occurred on 05/24/23. This policy, dated 12/09/22, stated, ". . . While the use of PRN psychotropic medications is not encouraged, if a PRN physician's order is received, ensure that the order has clear parameters . . . It is important to initiate other care plan interventions prior to the use of PRN psychotropic medications. . . . PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates	F 758	1. Resident # 5 had psychiatric services consult on 5/24/2023 with medication regime review. New orders that included 14 day stop order for PRN Olanzapine. Care plan updated with resident centered non-medication interventions for twice a day and PRN documentation. Nursing orders written for nursing documentation of mood and behaviors, with interventions and response. Behavior Committee established as per GSS Behavior Committee Policy and Procedure. 2. All residents receiving PRN psychotropic medications have the potential to be affected by this deficient practice. The Behavior Committee reviewed all residents receiving PRN psychotropic medications to ensure 14 days stop order is in place, care plans reviewed and updated for non-medication interventions if indicated. 3. All licensed nurses will be re-educated	

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F 758	Continued From page 62 the resident for the appropriateness of the medication. . . ." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance, Alzheimer's disease, and restlessness and agitation. Current physician's orders included Haldol (an antipsychotic) 2.5 milligrams (mg) intramuscular (IM) every four hours PRN (started on 05/03/23) for severe agitation related to dementia and Zyprexa (an antipsychotic) 5 mg orally (PO) every 24 hours PRN (started 05/01/23) for agitation related to "restlessness and agitation." Discontinued medication orders included Zyprexa 5 mg IM every 2 hours PRN for aggression/agitation to others (started 04/13/23 and discontinued 04/27/23). The PRN Haldol IM and Zyprexa PO lacked end dates or re-evaluation by the prescriber to continue the medications past 14 days. The medication administration record (MAR) identified Resident #5 received PRN Zyprexa 5 mg PO (with a start date of 05/01/23) on May 15, 19, and 23. Resident #5's current care plan identified non-pharmacological interventions including one on one visits, listen to music, offer to go for walks, offer baby doll, look at pictures of kids, sit by the window, reading poems, and offer snacks and hydration. Resident #5's nurses' notes and MAR identified the following: *04/19/23 at 10:49 p.m.: ". . . resident aggressive with staff hitting, throwing things, charging at staff, yelling, staff tried to redirect resident with no	F 758	by administrator or designee on GSS Psychotropic Medication Policy and Procedure and GSS Medication: Unnecessary Policy and Procedures specific to 14 day stop order for PRN anti-psychotic medications, and required documentation related to residents behaviors, response to non-medication interventions and response to medications on 06/22 or prior to next schedule shift. System change: facility will utilize GSS Physician Fax / Communication form for PRN anti-psychotic medications to ensure communication to ordering provider includes number of times PRN medication was administered and effectiveness. . 4. DNS or designee will audit all residents receiving psychotropic medications documentation of moods / behaviors and effectiveness of treatment, care plan including nonmedication interventions and PRN stop order. Audits will be completed 1 X / month for 3 months, then quarterly X1. Any deficient practice identified will be communicated to the administrator. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendations. 5. Compliance Date: 6/23/2023	

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F 758	Continued From page 63 effect, Prn zyprexa injection given . . ." *04/23/23 at 10:41 p.m.: ". . . Res. [resident] was om [sic] her room & became combative at HS [bedtime]. She was unable to be redirected or comforted by nursing staff. She was swinging/punching & attempted to lift w/c [wheelchair]. 1 dose of PRN given -- effectiveness is unknown at this time. She is in tv room area showing s/sx [signs and symptoms] of emotional distress (she walked out of her room into this space) after PRN was given & this writer sat c [with] her for approx [approximately] 15 mins [minutes] to attempt to console her distress. Res. continues to use unintelligible speech to communicate. . . ." *04/25/23 at 3:00 p.m.: Zyprexa IM 5 mg - ". . . Restless and agitation . . ." *04/25/23 at 4:48 p.m.: ". . . Resident had some agitation today and was running and crying, going in/out of others rooms. Resident came into contact with another resident and hit that resident in the chest. . . ." *05/11/23 at 4:25 p.m.: Zyprexa PO 5 mg - ". . . Delegated by charge nurse for restlessness and agitation . . ." *05/11/23 at 5:49 p.m.: ". . . Resident has been pacing, exit seeking and muttering angrily under her breath. Currently able to redirect. . . ." *05/14/23 at 7:01 p.m.: Zyprexa PO 5 mg - ". . . Given per nurse . . ." *05/15/2023 at 4:32 a.m.: ". . . resident was having increased agitation and crying episodes, increased restlessness and pacing gave prn medication at 1900 [7:00 p.m.] was ineffective resident kept having restlessness and anxiety was able to redirect and helped resident into bed around 1000 pm . . ." *05/15/2023 at 6:14 p.m.: Zyprexa 5 mg - ". . .	F 758		

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F 758	Continued From page 64 resident aggressive and agitated, needing to be redirected several times . . ." *05/16/23 at 12:42 a.m.: ". . . resident has had behaviors until 10 pm, agitation, pacing, charging at staff prn was given at 1800 [6:00 p.m.] with mild effectiveness, resident was no longer agitated but was tearfull [sic], and pacing and restlessness . . ." *05/16/23 at 3:00 p.m.: ". . . Resident continues to be agitated. Refused multiple attempts with oral medications. Resident was content in North activity area for some time. She recently became more agitated and was pacing, following residents and pulling on residents belongings. Staff was not able to fully redirect resident, she refused food, drink, bathroom and activity. PRN [IM Haldol] given for severe agitation. . . ." During an interview on 05/16/23 at 4:00 p.m., a staff member (#15) identified Resident #5 often has behaviors but "they gave her Haldol [today] so she isn't quite as bad." In the above instances, staff failed to attempt non-pharmacological interventions as identified in Resident #5's individualized behavior care plans (such as music, looking at pictures, offer baby doll, going for a walk, etc.). Failure to attempt diversional activities developed by staff prior to administering a PRN psychotropic may have resulted in Resident #5 receiving unnecessary psychotropic medications and experiencing adverse consequences related to their use.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		6/23/23

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F 761	Continued From page 65 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, information received from the complainant, and staff interview, the facility failed to accurately label a multi-dose insulin pen for 1 of 1 resident (Resident #19). Failure to label a multi-dose insulin pen may result in a resident receiving an inaccurate dose of medication and increases the risk of receiving another resident's insulin pen. Findings include: Observations on 05/16/23 at 11:52 a.m. showed an unlabel Basaglar insulin pen and without a	F 761	1. Resident # 19 does not have an order for insulin pen. 2. All residents with an order for insulin pen have the potential to be affected by this deficient practice. The facility has three (3) current residents with an insulin pen order. Insulin pens are labeled with resident's name and date of opening.	

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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 761	Continued From page 66 resident label. This pen was in a baggie with a labeled Novolog insulin pen for Resident #19. Staff member #15 stated that the unlabeled Basaglar insulin pen belonged to Resident #19, and that they were waiting on the label. During an interview on 05/17/23 at 11:00 a.m., an administrative staff member (#2) confirmed the pen was without a label and she expected facility staff to label all medication, including insulin pens, with the appropriate resident label. The facility failed to provide a policy on labeling of medications and multi-dose insulin pens.	F 761	3. All licensed nurses will be re-educated by administrator or designee on GSS Medication Acquisition, Receiving, Dispensing and Storage Policy and Procedure and Medication Insulin Administration / Insulin Pens Policy and Procedures specific to dating label when opening insulin pen or vials by 06/22/2023 . Local pharmacy notified and insulin pens will be dispensed to facility with label attached to pen. 4. DNS or designee will conduct observation audit of all medication storage areas to verify insulin pens have label attached with date opened present. Audits will be completed 1 X / week for 2 weeks, then every other week X 2, then 1 X / month X 2 months, then quarterly X1. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendations. 5. Compliance Date: 6/23/2023	