STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355093	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST , BOTTINEAU, North Dakota, 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
F0000	INITIAL COMMENTS The on-site revisit survey (for the complaint survey conducted on 05/13/25) and a facility reported incident (FRI) survey started on 07/09/25 and concluded on 07/16/25. The facility was found incompliance with regulatory requirements for the revisit survey. The facility was found noncompliant with regulatory requirements for the FRI survey. An extended survey was completed on 07/16/25.	F0000		08/06/2025
F0600 SS = SQC-J	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 involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on review of the facility reported incident (FRI) investigation, record review, review of facility policy, and staff interview, the facility failed to provide an environment free of mental/physical abuse for 1 of 1 sampled resident (Resident #1) Failure to prevent Resident #1 form the abusive actions of other residents (Resident #2 and #3) resulted in Resident #1 experiencing fear, anxiety, and injury. During the on-site FRI investigation survey, the team consulted with the State Survey Agency (SSA) on 07/10/25 at 12:19 p.m. and determined an immediate	F0600	Upon discovery, on 7/10/25: Immediate intervention for Resident #1, # 2, #3, and #4, the administrator and DNS met with GSS regional leadership and reviewed incidents and identified common factor is resident #1 impulsive actions. To prevent further occurrences, when resident #1 is in wheelchair and is mobile, the resident will have 1:1 supervision with immediate redirection when approaching other residents or being approached by other residents. Rural Psych Associates referral made for resident #1 on 7/10/25. On 7/10/25: All staff currently working and prior to start of next shift (at shift change huddle), were re-educated on “Understanding and Managing Triggers in Dementia Care”. Staff not on duty, were called and education provided verbally over the phone. All residents have the potential to be affected by this deficient practice. Facility Administrator, DNS and Social Services Designee re-educated by Good Samaritan Region Leadership on GSS Abuse and Neglect Policy and Procedure to provide an environment free of mental / physical abuse and protecting residents, specific to resident-resident altercations. All staff meeting lead by administrator on 7/15/25 on GSS Abuse and Neglect Policy and Procedure specific to protecting / preventing resident mental or physical harm specific to resident-to-resident altercations with review of “understanding and managing triggers in dementia care” training. Facility new system: Facility will increase frequency of Behavior Committee Meeting to weekly being 8/7/25 to identify residents who are exhibiting behaviors with the potential to impact others, implement person centered interventions, and monitor for efficacy of interventions.	08/13/2025

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

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

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F0600 SS = SQC-J	Continued from page 1 jeopardy (IJ) situation existed on 04/30/25. The facility failed to protect residents from abuse which resulted in resident-to-resident altercations. * 07/10/25 at 12:55 p.m., the survey team notified the Administrator and Director of Nursing (DON) of the IJ situation, provided the IJ template, and requested a removal plan for the IJ. * 07/10/25 at 3:30 p.m., the survey team reviewed and accepted the facility's removal plan. *07/16/25, the survey team verified the implementation of the removal plan and the IJ removal. The deficient practice remained at a G scope and severity following the IJ removal. The removal plan contained the following: * Resident #1 will have 1:1 supervision when mobile in his wheelchair. * The physician referred Resident #1 to Rural Psych Associates. * All staff received education on abuse, resident-to-resident altercations, and reporting. Findings include: Review of the facility policy titled "Abuse and Neglect" occurred on 07/10/25. This policy, dated April 2025, stated, ". . . The resident . . . has the right to be free from abuse . . . residents . . . must not be subject to abuse by anyone, including, . . . other residents . . .” Review of Resident #1's medical record occurred on 07/10/25. Diagnoses included Alzheimer’s disease, dementia, and anxiety disorder. An annual Minimum Data Set (MDS), dated 03/19/25, identified the resident severe cognitive impairment. The current care plan identified, ". . . has impaired cognitive function . . . or impaired thought processes . . . E/B [evidenced by] confusion, short- and long-term memory loss . . .” Review of Resident #2's medical record occurred on 07/10/25. Diagnoses included dementia, impulsiveness, and expressive language disorder. A quarterly MDS, dated 03/20/25, identified severe cognitive impairment. The current care plan identified, ". . . becomes uncomfortable at times with groups of people/loud areas E/B raises his voice, yells and at times curses . . . does not like to be touched by other resident’s . . . h/o [history of] resident to resident interactions . .	F0600	Continued from page 1 QAPI Coordinator RN or designee will audit behavior committee minutes and resident care plans to verify person centered care plan interventions are present and have been reviewed for effectiveness. Audits will be completed on all residents with documented behaviors 1 X / week for 4 weeks, then 1 X / month for 2 months, then random sample of 5 residents 1 X / quarter for 3 quarters. All audit findings will be submitted to the monthly QAPI Committee for review and recommendations. Compliance Date: 8/13/25	

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F0600 SS = SQC-J	Continued from page 2 ." Review of Resident #3's medical record occurred on 07/10/25. Diagnoses included behavioral and emotional disorders. A quarterly MDS, dated 06/15/25, identified severe cognitive impairment. The current care plan identified, ". . . has hallucinations/delusions . . . verbal behaviors . . ." -The FRI, dated 04/30/25, stated, ". . . [Resident #1] was sitting in wheelchair in E/W [east/west] commons area next to [Resident #2] who was also sitting in his wheelchair. [Resident #2] grabbed this resident's shirt sleeve and hit him multiple times with a closed fist. . . ." Review of facility video footage, dated 04/30/25, showed Resident #2 backed up and parked his wheelchair in front of the nurse's station. Resident #1 propelled his wheelchair toward Resident #2, grabbed his wheelchair, and moved him forward. Resident #2 grabbed Resident #1's sleeve and punched him in the arm three times with a closed fist before staff intervened. -The FRI, dated 05/03/25, stated, ". . . [Resident #1] told [Resident #2] to move old man and then . . . [Resident #1] was observed slapping at [Resident #2's] hands and forearms. [Resident #2] . . . slapped back before staff intervened. . . ." Review of facility video footage, dated 05/03/25, showed Resident #2 in his wheelchair near the dining room entrance. Resident #1 attempted to propel his wheelchair past Resident #2 and flinched when Resident #2 gestured, like he was going to strike him. Resident #1 attempted to propel his chair past Resident #2, when Resident #2 grabbed his wheelchair and started slapping him. Resident #1 retaliated by slapping Resident #2 before staff intervened. -The FRI, dated 07/06/25, stated, ". . . Floor nurse heard commotion, and two residents [Resident #1 and Resident #3] swearing at each other in the hallway by the conference room. The floor nurse turned the corner and found [Resident #1] tipped backwards in his wheelchair holding his head. . . ." Review of facility video footage, dated 07/06/25, showed Resident #1 in his wheelchair and Resident #3 approached him from behind. Resident #1 was attempted to propel his wheelchair forward when Resident #3 grabbed/tipped his chair and put her arm around his neck as he leaned backwards in her lap.	F0600		

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F0600 SS = SQC-J	Continued from page 3 During an interview on 07/10/25 at 1:00 p.m., two administrative staff members (#1 and #2) confirmed the altercations occurred and the altercation on 07/06/25 resulted in a large hematoma to the back of Resident #1's head requiring an emergency room visit. Facility staff failed to supervise residents and implement interventions in an effort to prevent Resident #1 from mental and physical abuse from other residents in the facility.	F0600		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on review of the facility reported incident (FRI) and review of facility policy, the facility failed to conduct a thorough investigation of physical abuse for 3 of 3 sampled residents (Resident #1, #2, and #3). Failure to investigate all allegations of abuse and ensure all residents were protected during the investigation placed Residents #1, #2, and #3 and all facility residents at risk for possible abuse, mental an emotional distress, and/or physical injury. thoroughly investigate allegations of abuse for 1 of 1 sampled resident (Resident #1). Failure to thoroughly investigate all abuse allegations, ensure Resident #1 was protected during each investigation, and implement corrective actions/evaluate their effectiveness following each investigation, placed Resident #1 and	F0610	Upon discovery, on 7/10/25: Immediate intervention for Resident #1, #2, and #3 the administrator and DNS met with GS regional leadership and reviewed incidents and investigations. Facility investigative team: administrator, DNS and Social Services Designee received education by GS Regional support consultant team on GS Abuse and Neglect Policy and Procedure specific to immediate, thorough investigation with documentation. All residents have the potential to be affected by this deficient practice. On 7/10/25, Administrator and DNS re-educated by GS RCSD RN on new facility system: To prevent further deficient practice, the regional clinical services director or designated regional support leader will meet with administrator and DNS weekly and as needed to review in progress investigations and provide feedback on improving thoroughness of investigations. Administrator re-educated all staff on 7/15/25 on GS Abuse and Neglect Policy and Procedure specific to immediate reporting of incidents, specific to resident-to-resident altercations to facility investigative team / administrator so investigation can be initiated immediately. GS RCSD RN or designee will audit if weekly meeting with GS Regional Support Consultant occurs, will audit incident investigation documentation to verify completed by 5th business day. Audits will be completed on 100% of incidents 1 X / week for 4 weeks, then on 50% of incidents 1 X / month for 2 months, then random sample of 10 incidents 1 X / quarter for 3 quarters. Any deficient practice identified will be immediately addressed. All audit findings will be submitted to the monthly QAPI Committee for review and recommendation. Compliance Date: 8/13/24	08/13/2025

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F0610 SS = D	Continued from page 4 other residents at risk for possible abuse. Findings include: Review of the facility policy titled "Abuse and Neglect" occurred on 07/10/25. This policy, dated April 2025, stated, ". . . 6. The investigation team . . . will review all events no later than the next working day following the event. 7. Ensure that someone is assigned to complete the investigation and that the care plan has been updated with any new interventions . . . 8. The investigation may include interviewing employees, residents/clients or other witnesses to the event. . . ." The FRI, dated 04/30/25, stated, ". . . [Resident #1] was sitting in wheelchair in E/W [east/west] commons area next to [Resident #2] who was also sitting in his wheelchair. [Resident #2] grabbed this resident's shirt sleeve and hit him multiple times with a closed fist. . . ." The FRI investigation report, dated 05/03/25, stated, ". . . [Resident #1] told [Resident #2] to move old man and then . . . [Resident #1] was observed slapping at [Resident #2's] hands and forearms. [Resident #2] . . . slapped back before staff intervened. . . ." The FRI investigation report, dated 07/06/25, stated, ". . . Floor nurse heard commotion, and two residents [Resident #1 and Resident #3] swearing at each other in the hallway by the conference room. The floor nurse turned the corner and found [Resident #1] tipped backwards in his wheelchair holding his head. . . ." The facility lacked evidence of thorough investigations related to abuse and failed to protect all residents during the investigation.	F0610		