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 _____	R-C 07/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An unannounced onsite revisit and additional complaint investgations survey was completed on July 18-19, 2023.	{F 000}		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		7/24/23

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

Electronically Signed | 08/01/2023

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

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 _____	R-C 07/19/2023

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 656	Continued From page 1 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility policy, and staff interview, the facility failed to implement the comprehensive care plan for 2 of 11 sampled residents (Resident #3 and #10). Failure to implement the comprehensive care plan that includes the services to be provided to the resident may negatively impact the resident's quality of care. Findings Include: Review of the facility policy titled "Care Plan" occurred on 07/19/23. 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. . . ." - Review of Resident #10's medical record occurred on all days of survey. The care plan stated, ". . . The resident has impaired ability to manage hot beverages . . . Provide cup with lid. .	F 656	1. Upon discovery, on 07/19/23, Director of Food and Nutrition educated dietary aide working at time of occurrence, for all residents needing lids on hot beverages that lid must be put on after pouring / prior to serving. An updated list of residents needing lids on hot liquids was provided to dietary aide, posted in kitchen, and at the nurse's station. 2. All residents at risk for managing hot liquids have the potential to be affected by this deficient practice. All current residents care plans reviewed and updated for hot beverage safety if indicated. 3. All dietary and nursing staff were	

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 _____	R-C 07/19/2023

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 656	Continued From page 2 . ." Observation on 07/18/23 at 12:05 p.m. showed Resident #10 sitting at the dining room table with a cup of coffee with no lid. The coffee cup lid sat on the table near the resident. At 12:15 p.m. Resident #10 received her meal and staff moved all the liquids closer to the resident and failed to place the lid on the coffee cup. - Review of Resident #3's medical record occurred on all days of survey. The care plan stated, ". . . The resident has impaired ability to manage hot beverages . . . Provide cup with lid. . . ." Observation on 07/18/23 at 12:20 p.m. showed Resident #3 eating her meal at the dining room table with a cup of coffee with no lid. During an 07/19/23 at 10:55 a.m., two administrative staff members (#2 and #3) confirmed Resident #3 and #10 require a lid on their coffee cup.	F 656	re-educated by interim DNS by 07/24/2023 on providing care as per care plan, specific to all residents that have care plan to have a lid on cup of hot beverages, must have the lids on their beverage before serving it to the resident. If a resident removes the lid, to remind them why they have the lid, and if resident continues to remove lid to report and document. The Director of Food and Nutrition or designee will maintain an up-to-date list of residents requiring lids which will be posted in the kitchen and located at nurse's station. 4. Director of Food and Nutrition or designee will conduct observation audits for lids on hot beverages as per resident's care plan. Observation audits will be conducted on random meals 3 X / week for 2 weeks, then 1 X / week for 2 weeks, then 1 X / month for 2 months. All audit results will be submitted to the monthly QAPI Committee for review and recommendation.	
{F 725} SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of	{F 725}		7/24/23

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 _____	R-C 07/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 725}	Continued From page 3 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 the complainant, review of facility policy, review of facility education, review of the facility call light logs and resident interviews, the facility failed to provide sufficient nursing staff and related services to meet the residents' needs for 3 of 11 sampled residents (Resident #1, #7 and #8). 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 identified concerns with extended call light	{F 725}	1. Re-education to nursing staff was initiated by the administrator on 7/20/23 on the priority of answering call lights prior to assisting residents not having an emergent need. Resident #1 plan of care was updated to include 1:1 weekly scheduled visit with activities to meet her non-clinical, non-emergent needs. Beginning on 7/20/23, DNS or designee is reviewing call light report, with resident interview, investigation, and follow-up for all extended response times. Facility initiated leadership rounding to assist in answering call lights and visiting with resident and staff regarding any needs.	

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 _____	R-C 07/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 725}	Continued From page 4 response times. Review of the facility policy titled "Call Light" occurred on 07/19/23. 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. . . ." Review of the education provided to all staff dated 06/22/23, stated, ". . . All employees can answer a resident call light - facility goal is 15 minutes or less response time. . . ." During interviews, when asked about sufficient staff/response to call lights, residents made the following statements: *07/19/23 at 8:30 a.m., Resident #1 stated, "Last Thursday [07/13/23] I did not get help till after 8 [a.m.]. I put my call light on at 6:30 [a.m.] and it stayed on until I called the front desk at 7:25 [a.m.] [using cell phone] and asked for help. At 7:42 [a.m.] a nurse came in and took my vital signs as I was upset . . ." Review of the call light log identified on 07/13/23, Resident #1 activated the call light at 6:37 a.m., and staff responded 1 hour and 11 minutes later. * 07/19/23 at 4:30 p.m., Resident #7 stated, "It's normal to have to wait for 20-30 minutes for them to come get me off the toilet. . . ." Review of the call light log from July 10-19, 2023 identified three occasions Resident #7's call light was on for more than 15 minutes. * 07/19/23 at 4:20 p.m., Resident #8 stated, "I have wet my pants waiting for them [the staff]) to answer my light. It just happened this morning. . . ."	{F 725}	2. All residents have the potential to be affected by this deficient practice. 3. All nursing staff were re-educated on GSS Call Light Policy and Procedure with staff expectations to meet residents needs timely by interim DNS by 07/24/2023. Facility administrator contacted call light vendor on 07/20/23 for education and support on the system. Leadership rounding will be ongoing. 4. DNS or designee will audit call light report with follow up action for any extended response times. Audits will be completed 3 days / week for 2 weeks, then 1 day / week for 2 weeks, then 1 X / month for 2 months. All audit findings will be submitted to QAPI Committee for review and recommendations.	

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 _____	R-C 07/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 725}	Continued From page 5 Review of call light log reports for the 300 and 400 units from 07/10/23 through 07/19/23 at 8:00 a.m. identified staff's response time to call lights exceeded 15 minutes 27 times.	{F 725}		
{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 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, review of facility policy, and staff interview, the facility failed to accurately label multi-dose insulin pens for 2 of 3 sampled	{F 761}	1. Upon discovery, interim DNS provided point-in-time re-education to staff involved on ensuring insulin pen has label and to	7/24/23

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 _____	R-C 07/19/2023

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 6 residents (Resident #7 and #11) with insulin. Failure to label multi-dose insulin pens with the open date and ensure the insulin pens have an identifying label, increases the risk of residents receiving outdated medications with reduced efficacy and/or the wrong medication. Findings include: Review of the facility policies occurred on 07/19/23. Facility policy titled, "Medication: Administration including Scheduling and Medication Aides", dated March 2023, stated, ". . . For medication designed for multiple administrations (e.g., inhalers, eye drops, insulin), the employee opening the medication writes the open date on the label to promote correct administration. . . ." Facility policy titled, "Medication: Insulin Administration, Insulin Pens", dated April 2023, stated, ". . . Purpose: To allow for safe use of insulin pens . . . Insulin pens must be clearly labeled with the name or other identifiers to verify that the correct pen is used on the correct person. . . ." Observations of the medication cart on the afternoon of 07/18/23 showed Resident #7 ' s Basaglar insulin pen lacked an open date and Resident #11 ' s Levemir pen lacked a label identifying the resident ' s name and open date. During an interview on 07/18/23 at 12:05 p.m., a medication aide (MA) (#4) confirmed the Basaglar pen lacked an open date and the Levemir pen lacked an identifying label. During an interview on 07/19/23 at 11:55 a.m., an administrative nurse (#1) stated it is the	{F 761}	document open date at time of opening. Insulin pen for resident # 7 was labeled with open date. Insulin pen for Resident #11 was properly labeled with open date and resident name. 2. All residents with insulin pens have the potential to be affected by this deficient practice. DNS did visual inspection of all other insulin pens, and they all had label and date open present. 3. Re-education provided to all licensed nurses and certified medication aides by interim DNS by 07/24/2023 on labeling and dating of medications. Facility pharmacy provider applies proper label on both insulin pen and on box. Local pharmacy provider has agreed to provide label for insulin pens to match box label for all insulin pens received from IHS (Indian Health Service). 4. DNS or designee will do inspection / observation audit of all insulin pens for presence of label and open date. Audits will be completed 3 days / week for 2 weeks, then 1 day / week for 2 weeks, then 1 X / month for 2 months. Any deficient practice identified will be addressed upon discovery. All audit results will be submitted to the monthly	

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 _____	R-C 07/19/2023

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 7 expectation staff label and date insulin pens when opened.	{F 761}	QAPI Committee for review and recommendations.	