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 09/11/2025

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 Standard Medicare/Medicaid recertification survey started on 09/08/25 and concluded on 09/11/2025.	F0000		09/30/2025
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide reasonable accommodation of needs regarding call lights for 1 of 18 sampled residents (Resident #19) observed during cares. Failure to ensure residents can reach/access the call light may result in unmet needs and the inability to call for help. Findings include: Review of the facility policy titled "Call Light" occurred on 09/11/25. This policy, dated July 2025, stated, ". . . PURPOSE to ensure residents always have a method of calling for assistance . . . when leaving the room, place call light within easy reach of resident. . . ." During an observation on 09/08/25 at 4:18 p.m., Resident #19 asked this surveyor, "Can you give me that call light back there? I want to lay down." Observation showed the resident's call light not within reach. Observation on 09/08/25 at 5:05 p.m. showed Resident #19's call light remained out of reach and at 5:15 p.m., staff assisted the resident to the dining room. Observation on 09/09/25 at 1:41 p.m. showed two certified nurse aides (CNAs) (#2 and #3) assisted Resident #19 with a transfer. The CNAs failed to place the resident's call light within reach before exiting	F0558	1)Education provided to staff with memo posted at time clock related to GSS “Routine Practices” Policy and Procedure specific to call light within resident reach. 2) All residents have the potential to be affected by this deficient practice. Baseline observation audits for call light placement for all current residents were completed on 9/19/25 and 9/22/25 with findings call lights within reach for all residents in their room during time audits were conducted. 3)All staff education provided by administrator or designee on GSS “Routine Practices” Policy and Procedure, specific to call light within resident reach and reminder all employees have the responsibility to ensure call light is within resident reach prior to leaving a resident room. Staff educated by attending one of the all-staff meeting held on10/6/25 and 10/7/25 or prior to compliance date. New Facility Practice: CNA will check all residents’ rooms for call light placement each day during AM, PM, and HS freshwater pass. 4)DNS or designee will conduct observation audits of 100% current resident rooms to ensure call lights are within reach of resident when in resident room. Audits will be completed on varying shifts 1 X / week for 4 weeks, then 1 X / month for 2 months, then 1X / quarter for 3 quarters. All audit findings will be submitted to the monthly QAPI Committee for review and recommendations. 5)Compliance Date: 10/10/2025	10/10/2025

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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F0558 SS = D	Continued from page 1 the room. During an interview on 09/11/25 at 1:30 p.m., an administrative staff member (#1) confirmed she expected staff to place the residents' call light within reach prior to exiting the room.	F0558		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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 record review, review of facility policy, and staff interview, the facility failed to report an alleged violation of abuse and neglect to the State Survey Agency (SSA) for 1 of 2 residents (Resident #36) with an unwitnessed fall resulting in an injury and hospital admission. Failure to report alleged incidents to the SSA placed Resident #36 and other residents at risk for possible abuse and/or injury. Findings include:	F0609	F609 – Reporting of Incident 1) Resident # 36 no longer resides in facility. 2) All residents have the potential to be affected. 3) Facility investigative team (administrator, social worker, and DNS) educated on GSS Abuse and Neglect Policy and Procedure specific to SSA reporting criteria by ND Memorandum for Reporting. Education provided by Regional Clinical Services Director RN and Regional Senior Director RN to investigative team by compliance date. All staff educated on the GSS Abuse and Neglect Policy and their role in reporting timely. Staff educated at all-staff meeting held on 10/6/25 and 10/7/25 or prior to compliance date. New facility practice: Facility investigative team will notify GSS RCSD and / or GSS Senior Director on all falls with injury to verify reporting criteria. All incidents are reviewed at clinical meeting each business day to verify reporting criteria is followed. 4) QAPI RN or designee will audit incidents, to verify if incident met criteria for reporting to SSA as per ND Memorandum for reporting, if yes did reporting occur within the 2- or 24-hour time frame requirements. Audit of 100% of incidents will be audited 1 X /week for 4 weeks, then 50% incidents will be audited 1 X / month for 2 months, then random sample of 5 incidents 1X / quarter for 3 quarters All audit findings will be submitted to the monthly QAPI Committee for review and recommendations.	10/10/2025

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F0609 SS = D	Continued from page 2 Review of the facility policy titled "Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy & Rehab" occurred on 09/10/25. This policy, dated, 04/04/25, stated, ". . . PURPOSE To ensure that all identified events of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported . . . ." Review of Resident #36's medical record occurred on all days of survey. Diagnoses included non-Alzheimer's dementia. An admission Minimum Data Set (MDS), dated 06/19/25, identified moderate cognitive impairment. Review of progress notes identified the following: * 09/03/25 at 05:46 p.m., "Date and Time of event: 9-3-25 @0405 (at 4:05 a.m.) . . . resident found slumped against the door to their bathroom with their head and shoulders leaning against the door. . . . Obvious laceration with active bleeding to right frontal/parietal skull. . . .additional laceration to R [right] rear parietal/occipital skull noted. . . . Bleeding to scalp . . . Resident's v/s [vital signs] obtained and found to be hypoxic [inadequate oxygen level] initial SpO2 [peripheral oxygen saturation] was 68 RA [room air]. Resident unsure of how they fell or why they were up. . . . * 09/03/25 at 10:08 a.m., stated, ". . . Spoke with ER [emergency room] and notified that resident was admitted to the hospital for pneumonia." * 09/04/25 at 9:42 a.m., stated, ". . . hospital notified facility of resident's death. . . ." During an interview on 09/11/25 at 12:56 p.m., an administrative staff member (#4) identified the facility completed an internal investigation, did not find the injury to be significant or of unknown origin, and did not complete a Facility Reported Incident (FRI) notification. The facility failed to identify Resident #36's injury as potential abuse or neglect and submit an incident report to the SSA.	F0609		
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a	F0637	1)Resident #2 will have a SCSA with ARD 10/3/25 completed. Resident #5 will have a SCSA with ARD 10/3/25 completed. 2)All residents have the potential to be affected by this deficient practice.	10/10/2025

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F0637 SS = D	Continued from page 3 "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a Significant Change in Status Assessment (SCSA) for 2 of 2 of sampled residents (Resident #2 and #5) who experienced a significant change in status. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status and identity and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.19.1), dated October 2024, page 2-24 stated, ". . . A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." Page 2-27 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . Any decline in an ADL [activities of daily living] physical functioning area (e.g., self-care or mobility) (at least 1) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individual's functioning. . . . " - Review of Resident #2's medical record occurred on all days of survey. A SCSA Minimum Data Set (MDS), dated 04/22/25, identified no wandering, partial/moderate assist with toileting, bathing, and lower body dressing, and supervision with upper body dressing and putting on/taking off footwear. A quarterly MDS, dated 07/16/25, identified wandering 1-3 days, substantial/maximum assistance with toileting, bathing, lower and upper body dressing, and	F0637	Continued from page 3 3)MDS Coordinator was educated by GSS Clinical Reimbursement Analyst on GSS MDS Policy and Procedure and RAI Manual Guidance specific to SCSA criteria on 9/16/25. New facility practice: The (IDT)Interdisciplinary clinical team will meet 1 X / week to review current residents with change of condition to verify criteria / need for SCSA MDS. 4)DNS or designee will audit IDT meeting minutes to verify residents reviewed for SCSA criteria with appropriate action taken as indicated. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months, then 1X / quarter for 3 quarters. All audit findings will be submitted to the monthly QAPI Committee for review and recommendations. 5)Compliance Date: 10/10/2025	

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F0637 SS = D	Continued from page 4 putting on/taking off footwear. - Review of Resident #5's medical record occurred on all days of survey. An annual MDS, dated 01/10/25, identified no mood indicators, no behaviors, wandering 1-3 days, substantial/maximum assistance with lower body dressing, and partial/moderate assistance with roll left to right (bed mobility). - A quarterly MDS, dated 04/10/25, identified 0-3 mood indicators, verbal behaviors 4-6 days, other behaviors 1-3 days, wandering 4-6 days, dependent with lower body dressing, and substantial/moderate assistance with roll left to right. The record lacked evidence facility staff identified and/or completed a SCSA related to Resident #2's and #5's change in behaviors and decline in ADLs. During an interview on 09/10/25 at 4:22 p.m., an administrative staff nurse (#5) confirmed Resident #2 and Resident #5 declined and staff should have completed a SCSA.	F0637		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F0641	1) MDS Coordinator modified Resident #21 Admission MDS on 9/11/25 to include Hospice. Modified MDS was accepted on 9/12/25. No action can be taken on Resident #2 and Resident #5 MDS with dashes. 2) All residents on hospice have the potential to be affected by this deficient practice. Upon discovery, facility had 1 additional current resident on hospice with accurate MDS coding. 3)MDS Coordinator was educated by GSS Clinical Reimbursement Analyst on GSS MDS Policy and Procedure and RAI Manual Guidance specific to Hospice coding and complete documentation to prevent dashes on 9/16/25. New Facility Practice: Clinical team meeting held each business day will review current residents on Hospice and IDT meeting held weekly will review all residents in MDS look back period to review documentation to prevent dashes at time of MDS completion. 4)DNS or designee will audit 100% of hospice residents MDS prior to submission to ensure accurate hospice coding and will audit 5 random MDS for dashes. Any deficient practice identified will be addressed immediately. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months, then 1X / quarter for 3 quarters. All audit findings will be submitted to	10/10/2025

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F0641 SS = D	Continued from page 5 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 12 sampled residents (Resident #2, #5, and #21) reviewed. Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION C: COGNITIVE PATTERNS The Long-Term Care Facility RAI User's Manual, revised October 2024, page C-24, of the RAI Manual stated, ". . . If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.,) and staff were unable to make a determination based on observation of the resident, use the standard 'no information' code (a dash, '-'), to indicate that the information is not available because it could not be assessed." SECTION D: MOOD The Long-Term Care Facility RAI User's Manual, revised October 2024, page D-3, of the RAI Manual stated, ". . . If the resident interview was not conducted within the look-back period . . . item D0100 must be coded 1, Yes, and the standard 'no information' code (a dash '-') entered in the resident interview items. . . ." SECTION GG: FUNCTIONAL ABILITIES The Long-Term Care Facility RAI User's Manual, revised October 2024, page GG-14, of the RAI Manual stated ". . . Individualized care plans should be based on an accurate assessment of the resident's self-performance and the amount and type of support being provided to	F0641	Continued from page 5 the monthly QAPI Committee for review and recommendations. 5)Compliance Date: 10/10/2025	

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F0641 SS = D	Continued from page 6 the resident. . . ." Page GG-21 stated ". . . A dash (“-”) indicates “No information.” CMS [Centers for Medicare & Medicaid Services] expects dash use to be a rare occurrence. . . ." - Review of Resident #2's medical record occurred on all days of survey. A quarterly MDS, dated 07/16/25, showed Section C and D dashed. The factors listed on page C-24 of the RAI manual did not apply to Resident #2. The facility failed to assess the resident's cognitive abilities and mood. - Review of Resident #5's medical record occurred on all days of survey. A quarterly MDS, dated 07/10/25, showed Section C, D and GG dashed. The facility failed to assess the resident's cognitive abilities, mood, and functional abilities. During an interview on 09/09/25 at 11:11 a.m., an administrative staff member (#5), stated, "If nursing staff doesn't complete those assessments I use dashes." SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS The Long-Term Care Facility RAI User's Manual, revised October 2024, page O-7, stated, ". . . O0110K1, Hospice care code residents identified as a being in a hospice program for terminally ill persons . . ." - Review of Resident #21's medical record occurred on all days of survey. A physician's order dated 06/27/25. stated, "Admit to skilled nursing facility under HOSPICE care." The current care plan stated, ". . . The resident has a terminal prognosis . . . Is on hospice care . . ." The facility failed to code hospice services on the admission MDS, dated 07/03/25. During an interview on 09/11/25 at 8:15 a.m., an administrative staff member (#5) confirmed staff failed to code hospice on Resident #21's MDS.	F0641		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F0657	1)Resident #3 insulin was discontinued and oral anti-diabetic medication ordered on 9/15/25. Resident #3 care plan updated to include Diabetes managed with blood glucose checks and oral anti-diabetic medication on 9/15/25. Resident # 3 Care plan interventions updated to include monitoring and interventions for hypoglycemia / hyperglycemia on 09/11/25. Resident #6 Diabetes care plan interventions were updated to include monitoring and interventions for hypoglycemia / hyperglycemia on 9/19/25.	10/10/2025

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F0657 SS = D	Continued from page 7 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 2 of 18 sampled residents (Resident #3 and Resident #6). Failure to update care plans limited the staff's ability to communicate needs and ensure continuity of care. Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education Inc., New Jersey, pages 203 and 212, stated, ". . . The nurse uses . . . care plans. . . . creates an individual plan for unusual . . . problems needing special attention. . . . Observations include assessments made to determine whether a complication is developing. . . . The nurse should write observations for both real problems and those for which the client is at risk." -Review of Resident #3's medical record occurred on all days of survey. Diagnoses included diabetes, and a physician's order for insulin. The resident's care plan lacked monitoring for signs/symptoms and interventions	F0657	Continued from page 7 2)All residents with diabetes have the potential to be affected by this deficient practice. Baseline care plan audits completed on all current residents receiving anti-diabetic medication on 9/19/25. 3)All licensed nurses will be educated by MDS Coordinator or designee on care planning for residents with Diabetes, specific to, care plan to include intervention for monitoring of hypoglycemia and hyperglycemia. Staff educated by attending one of the all-staff meeting held on10/6/25 and 10/7/25 or prior to compliance date. New Facility Practice: Admissions, re-admissions, and current residents with new orders for anti-diabetic medication / glucose monitoring will be reviewed at clinical meeting each business day and update care plan if indicated for hypoglycemia and hyperglycemia monitoring interventions. 4)Care plan audits will be completed on 100% of current residents with anti-diabetic medications for inclusion of intervention for monitoring of hypoglycemia and hyperglycemia. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months, then 1X / quarter for 3 quarters. All audit findings will be submitted to the monthly QAPI Committee for review and recommendations. 5)Compliance Date: 10/10/2025	

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F0657 SS = D	Continued from page 8 for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar). -Review of Resident #6's medical record occurred on all days of survey. Diagnoses included diabetes and a physician's order for glipizide (an oral antidiabetic). The resident's care plan lacked monitoring for signs/symptoms and interventions for hypoglycemia and hyperglycemia. During an interview on 09/11/2025 at 10:44 a.m., an administrative nurse (#1) stated staff failed to update the care plans for Resident #3 and Resident #6.	F0657		
F0658 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 manufacturer's instructions, review of professional reference and staff interview, the facility failed to ensure staff followed professional standards of practice for 1 of 2 supplemental residents (Resident #3) observed during medication administration. Failure to properly prepare insulin pens (Resident #3) may result in residents receiving the wrong medication dose and/or result in adverse health consequences. Findings include: Review of the facility policy titled “Medication: Insulin Administration, Insulin Pens, Insulin Pumps” 09/05/24, stated, “Intermediate or mixed insulins (. . . 70/30 . . .) . . . This type of insulin should be gently mixed before use. To mix, roll the pen between your hands. You must also turn the pen up and down ten times . . .” Review of manufacturer's instructions for the "NovoLog 70/30 Mix FlexPen, dated February 2023, stated, ". . . roll NOVOLOG MIX 70/30 FlexPen gently between hands in a horizontal position 10 times. Then, turn NOVOLOG MIX 70/30 FlexPen upside down so that the glass ball moves from one end of the reservoir to the other 10 times	F0658	1)Resident #3 Novolog 70/30 insulin was discontinued on 9/15/25. On 09/12/25, OnShift message to all licensed nurses and CMA II with education on the required technique of mixing intermediate and mixed insulins prior to administration. CLDS RN completed Insulin pen competency verification with licensed nurses and CMA II by 9/20/25. 2)All residents receiving intermediate or mixed insulins have the potential to be affected by this deficient practice. No current residents are receiving mixed or intermediate insulins. 3)Licensed nurses will be educated by DNS or designee on GSS Insulin Administration Policy and Procedure specific to intermediate and mixed insulin mixing procedure prior to administration. Staff educated by attending one of the all-staff meeting held on10/6/25 and 10/7/25 or prior to compliance date. New facility practice: Laminated instructions with illustration on required technique placed on medication carts on 09/12/25. 4)DNS or designee will conduct observation audits of insulin administration for all residents receiving intermittent or mixed insulins to ensure proper mixing technique is completed prior to administration. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months, then 1X / quarter for 3 quarters. All audit findings will be submitted to the monthly QAPI Committee for review and recommendations. 5)Compliance Date: 10/10/2025	10/10/2025

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 09/11/2025

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

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F0658 SS = D	Continued from page 9 until the suspension appears uniformly white and cloudy. Inject immediately. . . ." - Observations during medication administration showed the following: - 09/11/25 at 7:18 a.m. a medication aide (MA) (#7) primed the insulin pen and immediately administered Novolog mix 70/30 to Resident #3 (a combination insulin containing 70 percent immediate acting insulin and 30 percent rapid acting insulin) insulin without following the mixing protocol. During an interview on 09/11/25 at 1:30 p.m., a staff nurse (#1) stated she was unaware of the mixing process for a Novolog 70/30 insulin pen.	F0658		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide treatment and services to aid in the healing of a pressure ulcer for 1 of 2 sampled residents (Resident #26) with a current pressure ulcer. Failure to implement interventions as ordered may result in a new pressure area and delayed healing/deterioration of an unstageable pressure ulcer. Findings include: Review of the facility policy titled "Pressure Ulcers" occurred on 09/11/25. This policy, dated 02/17/25,	F0686	1)Wound Data Collection UDA and Wound RN Assessment UDA completed on resident #26 by RN with dressing change on 9/9/25. No change in wound r/t contact with soiled dressings, continues to be a healing pressure ulcer. Resident #26 care plan updated to include documentable intervention for resident refusal of pressure relieving boots / floating heels. Resident # 26 care plan updated to include specialty therapeutic air mattress, reposition for pressure relief with each check and change and prn. PCC Communication to nursing staff to provide care as per care plan specific to resident repositioning and application of pressure relieving boots / floating heels, refusals: document and report to nurse, and immediately report soiled wound dressings to nurse. 2)All residents at risk of pressure ulcers have the potential to be affected by this deficient practice. 3)Nursing staff educated by DNS or designee on GSS “Pressure Ulcer” policy and procedure, specific to providing care as per care plan – repositioning, pressure relieving boots / floating heels with documentation, including refusals, and report/changing soiled dressing immediately. Staff were educated by attending one of the all-staff meeting held on10/6/25 and 10/7/25 or prior to compliance date. New facility practice: Charge nurse will supervise CNA staff to ensure care is provided as per care plan and give direction as needed. 4)DNS or designee will conduct observation audits on all residents with pressure relieving boots / floating heels to verify placement, if not in place will verify	10/10/2025

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F0686 SS = D	Continued from page 10 stated, ". . . A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing. . . ." Review of Resident #26's medical record occurred on all days of survey. Diagnoses included diabetes mellitus and protein calorie malnutrition. A quarterly Minimum Data Set (MDS), dated 07/22/25, identified dependent on staff with rolling from side to side (bed mobility) and transfers, and an unhealed unstageable pressure ulcer. The current care plan stated, " . . The resident has pressure ulcer to sacral area. . . offer/assist to turn/reposition at least every 2 hours. . . . Provide open heel boots to bilateral feet or float heels on pillow . . ." A physician's order, dated 11/03/23, stated bilateral pressure relieving boots on while in bed and in chair. Observations on 09/09/25 showed Resident #26 seated in a wheelchair in the hallway by the nurses station from 8:08 a.m. until 1:23 p.m. (over 5 hours) without being repositioned. At 1:23 p.m. two certified nurse aides (CNAs) (#2 and #3) assisted Resident #26 with a check and change. Observation showed the pressure ulcer dressing to the coccyx soiled with bowel movement (BM). The CNA (#2) used a wipe to clean the BM from the resident's dressing. After cares the resident remained in bed, and the CNAs exited the room. The CNAs failed to notify the nurse of the soiled dressing and apply the pressure ulcer relieving boots. Observation on 09/09/25 at 3:51 p.m. showed Resident #26 remained in bed without pressure relieving boots or heels floated. During an interview on 09/09/25 at 5:23 p.m., a nurse (#22) stated the CNAs (#2 and #3) failed to report Resident #26's soiled dressing. Observation on 09/10/25 at 8:45 a.m. showed Resident #26 in bed without pressure relieving boots or heels floated. Observation on 09/10/25 at 10:20 a.m. showed two nurses (#6 and #23) changed Resident #26's pressure ulcer dressing. When completed, the resident remained in bed and the nurses exited the room without placing the pressure relieving boots or floating his heels on a pillow. Review of Resident #26's repositioning documentation from 08/12/25 to 09/09/25 showed the following:	F0686	Continued from page 10 refusal documentation is present, will conduct observation audits on all residents with repositioning plans to verify care provided as per care plan, observation of resident wound dressing to ensure clean and intact. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months, then 1X / quarter for 3 quarters. All audit findings will be submitted to the monthly QAPI Committee for review and recommendations. 5)Compliance Date: 10/10/2025	

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F0686 SS = D	Continued from page 11 1 day - occurred two times. 9 days - occurred three times. 14 days - occurred 4 times. 5 days - occurred five times. The number of hours between repositioning ranged from 2-24 hours. During an interview on 9/11/25 at 1:30 p.m., an administrative staff member (#1) stated she expected staff to turn and reposition residents every two hours, place pressure relieving boots when ordered, and care planned.	F0686		
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of the facility policy, and staff interview, the facility failed to ensure safe transfers for 2 of 7 sampled residents (Residents #1 and #34) and 1 of 1 supplemental resident (Resident #22) observed during transfers. Failure to assess the need for mechanical lifts and to use a gait belt placed residents at risk of serious injury. Findings include: Review of the facility policy titled "Mobility Support and Positioning" occurred on 09/11/25. This policy, dated 04/06/25, stated, ". . . Always check the Kardex, or care plan/service plan prior to the transfer or repositioning task for type and amount of assistance needed. Follow any specific lift/transfer instructions for the resident. . . ."	F0689	1)Resident #1 Sit-Stand-Walk UDA completed on 7/17/25 was reviewed by RN on 9/11/25 validating resident transfer with sit to stand lift was still appropriate. Care Plan updated on 9/11/25 Transfer: sit to stand lift, medium sling, 1 assist. Resident # 22 no longer in facility. Resident # 34 Sit-Stand-Walk UDA completed on 10/1/25, care plan updated Transfer: sit to stand lift, large sling, 1 assist. Upon discovery, on 9/11/25 Ecolab carpet spot remover was removed from Resident #26 room and properly stored. Upon discovery, verbal education was provided to maintenance and housekeeping staff by environmental services director on secure storage of chemicals. Clarification: Resident #2-tab door alarm is in place to alert staff of resident exiting room to prevent resident to resident incident, not a fall risk intervention. On 9/11/25 trialed motion sensor alarm for resident #2. Staff identified limited range of sensitivity so continued tag door alarm and placed order for new motion sensor. New sensor implemented on 9/25/25 with care plan update. 2)All residents have the potential to be affected by this deficient practice. 3)Education provided by DNS or designee to all nursing staff - CNA to report to nurse, changes in resident condition when staff feel change in transfer intervention is warranted. Nurse to give direction on immediate safe transfer technique, complete sit-stand-walk UDA and update care plan as indicated. Education provided to all staff on proper storage of chemicals, verifying resident alarm placement and functionality for resident safety. Staff educated by	10/10/2025

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F0689 SS = E	Continued from page 12 -Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, "TRANSFER . . . Total lift (Hoyer lift) with assist of 2 staff and large sling for transferring in/out of bed." Observation on 09/11/25 at 7:00 a.m. showed a certified nurse aide (CNA) (#3) placed a mechanical sit to stand lift outside the door of Resident #1's room. During an interview on 09/11/25 at 7:00 a.m., when asked if any residents on the 300 hallway required a Hoyer lift, the CNA (#3) stated, "No, they [residents] are located in the other wing." During an interview on 09/11/25 at 7:20 a.m., the CNA (#3) stated she used the sit to stand lift to transfer Resident #1 from the bed. During an interview on 09/11/2025 10:44 a.m., an administrative nurse (#1) stated she would expect the CNAs to follow the current care plan and use a total lift with assist of two staff to transfer Resident #1 from the bed. -Review of Resident # 22's medical record occurred on all days of survey. The current care plan stated, ". . . TRANSFER - Transfer Between Surfaces: With total lift x2 [with two] staff . . . Resident is unable to weight bear with total lift assist x 2 . . ." During an observation on 09/09/25 at 4:15 p.m., two CNAs (#11 and #12) transferred Resident #22 from the recliner to a wheelchair. One CNA (#11) applied a gait belt and both CNAs (#11 and #12) attempted to stand the resident. The resident could not bear weight and the CNAs lifted him with the gait belt to the wheelchair. One CNA (#11) stated, "he was a [mechanical] lift but today they [administrative staff] said he can pivot." During an observation on 09/11/25 at 5:30 a.m., a CNA (#13) assisted Resident #22 with toileting. The CNA (#13) positioned the resident's wheelchair next to the toilet, directed the resident to hold onto the grab bar, and assisted the resident to stand by placing her hands under the resident's armpits and lifting. The CNA (#13) then called for assistance to transfer the resident off of the toilet. The CNA (#13) and the nurse (#14) directed the resident to hold onto the grab bar and assisted the resident to stand by lifting under the resident's arms. The CNA (#13) and nurse (#14) failed to utilize a mechanical lift or a gait belt. -Review of Resident #34's medical record occurred on all days of survey. Diagnoses included osteoporosis and	F0689	Continued from page 12 attending one of the all-staff meeting held on10/6/25 and 10/7/25 or prior to compliance date. New Facility Practice: Resident with change of condition will be reviewed at the clinical team meeting held each business day to verify need for Sit – Stand- Walk UDA completion / care plan update. Licensed nurses will check placement and functionality of alarms every shift with TAR documentation. 4)Environmental Services Director or designee will conduct observation rounding of resident rooms and resident common areas to verify proper chemical storage. DNS or designee will conduct observation audits on 3 residents to validate transfer care is provided as per care plan. DNS or designee will audit all residents with alarms verifying placement and functionality. Audits will be completed 1 X / week for 4 weeks, then 1X / month for 2 months, then 1X / quarter for 3 quarters. All audit findings will be submitted to the monthly QAPI Committee for review and recommendation. 5)Compliance Date: 10/10/2025	

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F0689 SS = E	Continued from page 13 history of a healed traumatic fracture. The current care plan stated, ". . . The resident has an ADL self-care performance deficit . . . E/B needs assist . . . TRANSFER - assist of 1 staff with transfers . . ." During an observation on 09/08/2025 at 4:15 p.m., a CNA (# 3) assisted the resident to toilet using a stand lift. The CNA failed to transfer the resident as care planned. During an interview on 09/11/25 at 10:45 a.m. an administrative staff member (#1) confirmed the facility allowed CNAs to decide whether to use a lift, "they can always go up [use a lift]" but they can't go down [not use a lift] if care planned but confirmed she expected staff to use a gait belt with all pivot transfers. The facility failed to have a nurse assess and update the care plan for a change in resident's condition requiring the use or discontinuation of a mechanical lift. 2. Based on observation, record review, review of facility policy, and resident and staff interviews, the facility failed to ensure an environment free of accidents and hazards for 2 of 2 sampled residents (Resident #2 and #26) observed with a door alarm and cleaning chemicals in the room. Failure to ensure a functioning door alarm for Resident #2 placed the resident at risk for falls/injury. Failure to ensure Resident #6's room remained free from chemicals placed the residents at risk for injury. Findings include: Review of facility policy titled "Alarms- Bed, Chair, and Door" occurred on 09/11/25. This policy, dated August 2025, stated, ". . . Nursing staff will be responsible for visually checking placement of alarms . . ." Review of facility policy titled "Housekeeping, Standard or Light Cleaning" occurred on 09/11/25. This policy, dated August 2025, stated, ". . . No Cleaning supplies . . . should be . . . in the resident rooms. . . ." Review of the Safety Data Sheet for Ecolab carpet spray remover, dated 08/26/19, stated, ". . . Causes serious eye irritation. . . . Avoid contact with skin and eyes . . ."	F0689		

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F0689 SS = E	Continued from page 14 - Observation on all days of survey showed a spray bottle of Ecolab carpet spot remover located on Resident #26's bed side table. During an interview on 09/11/25 at 1:40 p.m., an administrative staff member (#10) stated, "Chemicals should not be left in resident rooms." - Review of Resident #2's medical record occurred on all days of survey. The care plan stated, ". . . resident has an ADL [Activities of Daily Living] self-care performance deficit . . . mobility deficits, shuffled gait . . . Alarm to door to alert staff when resident comes out of his room . . ." Observation on 9/11/25 at 5:31 a.m. showed Resident #2 ambulated out his room into the hallway without the door alarm sounding. The resident walked across the hall, approached a CNA (#18) and stated, "Bathroom." The CNA assisted the resident back to his room and activated the resident's call light for assistance. At 5:36 a.m., a nurse (#19) answered the resident's call light and the CNA (#18) reported to the nurse the door alarm was not hooked up. The facility staff failed to ensure Resident #2's door alarm remained connected. During an interview on 9/11/25 at 1:30 p.m., an administrative staff member (#1), stated she expected staff to ensure Resident #2's door alarm was connected. Review of Resident #1's medical record occurred on all day of survey and identified diagnoses including other poly-osteoarthritis, adult failure to thrive, and secondary malignant neoplasm of the breast. The current care plan stated, "TRANSFER . . . Total lift with assist of 2 staff and large sling for transferring in/out of bed. Observation on 09/11/25 at 7:00 a.m. showed a certified nurse aide (CNA) (#3) parked a mechanical sit to stand lift outside the door of Resident #1's room. During an interview on 09/11/25 at 7:00 a.m. a CNA (#3), when asked if any residents on the 300 hallway required a Hoyer lift (full body lift), the CNA stated, "No, they are located in the other wing." During an interview on 09/11/25 at 7:20 a.m. the CNA (#3), stated, she used the sit to stand lift to transfer Resident #1 from the bed to the wheelchair." During an interview on 09/11/2025 10:44 a.m., an	F0689		

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F0689 SS = E	Continued from page 15 administrative nurse (#1) stated she would expect the CNAs to follow the current care plan and use a total lift with assist of two staff for transferring Resident #1 from the bed.	F0689		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide appropriate toileting for 1 of 5 sampled residents (Resident #2) observed during toileting. Failure to provide timely toileting may result in a loss of dignity and placed the resident at risk for skin breakdown, poor grooming/hygiene, decreased	F0690	1)Resident #2 care plan updated to offer toileting / change brief upon arising, before and after meals, HS and prn at night on 10/1/25. 2)All residents requiring staff assistance with toileting have the potential to be affected by this deficient practice. 3)Nursing staff will be educated by DNS or designee on GSS “Activity of Daily Living” policy and procedure, specific to assisting residents with toileting as per care plan. Staff educated by attending one of the all-staff meeting held on10/6/25 and 10/7/25 or prior to compliance date. New facility practice: Charge nurses will supervise CNA staff to ensure care is provided as per care plan and give direction as needed. 4)DNS/designee will conduct observation audits on 3 staff assisting residents with toileting to verify care is provided as per care plan. Audits will be completed 1 X / week for 4 weeks, then 1X / month for 2 months, then 1X / quarter for 3 quarters. All audit findings will be submitted to the monthly QAPI Committee for review and recommendation. 5)Compliance Date: 10/10/2025	10/10/2025

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F0690 SS = D	Continued from page 16 self-esteem, urinary tract infections, and fall and/or injuries. Findings include: Review of the facility policy titled "Activities of Daily Living" occurred on 09/11/25. This policy, dated 12/23/24, stated, ". . . Any resident who is unable to carry out activities of daily living will receive necessary services to maintain . . . grooming and personal and oral hygiene. . . ." Review of Resident #2's medical record occurred on all days of survey. The care plan identified the following, ". . . TOILET USE: Resident requires assist of 1 staff. . . . TOILETING PROGRAM: Offer resident the toilet every 2 hours when awake . . . BRIEF USE: . . . Check Q2 [every] 2 hours and prn [as needed]." During an observation on 09/09/25 at 3:05 p.m., a certified nurse aide (CNA) (#9) assisted Resident #2 to the bathroom. The resident's incontinent product and shorts were saturated with urine. Review of the resident's toileting log for 09/09/25 showed staff last assisted the resident with toileting at 11:31 a.m. (3.5 hours prior). Review of Resident #2's toileting log, dated 08/13/25 through 09/10/25, showed additional five occasions, (08/13/25, 08/16/25, 08/17/25, 09/05/25, 09/07/25) when staff failed to toilet the resident every two hours. The occasions ranged from 4 to 11 hours between toileting times and resulted in urinary and bowel incontinence. During an interview on 09/11/25 at 1:30 p.m., a nurse (#1) stated, "If a resident is in a brief, the expectation is to check and change them every two hours."	F0690		
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services	F0849	1)Hospice election form completed on 6/27/25 received from hospice agency on 9/11/25 and scanned into PCC OnBase repository. 2)All residents receiving hospice services have the potential to be affected by this deficient practice. On 9/19/25, audit conducted on 2 other current residents receiving hospice with hospice election form scanned into PCC OnBase repository. 3)Facility admission team (DNS, MDS, Social Services and HIM) educated on the requirement to obtain	10/10/2025

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

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F0849 SS = D	Continued from page 17 at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course	F0849	Continued from page 17 completed hospice election form by GSS RCSD RN on 10/1/25. New Facility Practice: HIM Director will verify facility has received hospice election form in each business day morning report for all residents admitted with hospice/ new order for hospice services. 4)Social services or designee will audit 100% of residents on hospice to verify facility has completed hospice election form scanned into PCC OnBase repository. Audits will be completed 1 X / week for 4 weeks, then 1X / month for 2 months, then 1X / quarter for 3 quarters. All audit findings will be submitted to the monthly QAPI Committee for review and recommendation. 5)Compliance Date: 10/10/2025	

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F0849 SS = D	Continued from page 18 of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.	F0849		

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F0849 SS = D	Continued from page 19 The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each	F0849		

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F0849 SS = D	Continued from page 20 resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to ensure resident records contained the hospice election form for 1 of 1 sampled resident (Resident #21) receiving hospice services. Failure to obtain the form limits staff's ability to ensure coordination of care between the facility and the hospice. Findings include: Review of Resident #21's medical record occurred on all days of survey and identified Resident #21 elected hospice services on 06/27/25. The care plan stated, ". . . The resident . . . Is on hospice care . . ." The medical record lacked the hospice election form. During an interview on 09/11/25 at 12:30 p.m., an administrative staff member (#20) confirmed the medical record lacked the hospice election form.	F0849		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing	F0880	1)Clinical staff were educated on Enhanced Barrier Precautions by RN CLDS by September 30, 2025. Moments of hand hygiene and no gloves in uniform pockets memo posted at time clock. 2)All residents have the potential to be affected by this deficient practice. 3)Infection Prevention RN or designee will educate facility staff on GSS Hand Hygiene Policy and Procedure, specific to moments of hand hygiene with reminder to staff “gloves cannot be stored in uniform pocket”, GSS “Standard, Enhanced Barrier and Transmission-Based Precaution” Policy and Procedure specific to PPE use for EBP. Staff educated by attending one of the all-staff meeting held on10/6/25 and 10/7/25 or prior to compliance date. New facility practice: Hand hygiene moments posted by resident bathroom glove dispensers / hand sanitizer dispensers. 4)Infection prevention RN or designee will conduct	10/10/2025

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F0880 SS = E	Continued from page 21 services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F0880	Continued from page 21 observation audits of 3 random staff members performing resident cares to ensure proper PPE use and hand hygiene moments completed. Audits will be completed 1 X / week for 4 weeks, then 1X / month for 2 months, then 1X / quarter for 3 quarters. All audit findings will be submitted to the monthly QAPI Committee for review and recommendation. 5)Completion date 10/10/2025	

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F0880 SS = E	Continued from page 22 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interview the facility failed to follow standards of infection control for 5 of 11 sampled residents (Resident #4, #5, #26, #34, and #48) and 3 supplemental residents (Resident #19, #22 and #40) observed during cares. Failure to follow infection control practices during resident cares related to handling soiled linen, hand hygiene, glove use, and enhanced barrier precautions (EBP) has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 09/11/25. This policy, dated March 2022, stated, ". . . To establish hand hygiene as the single most important factor in preventing the spread of disease-causing organisms to patients and personnel in healthcare settings . . . Procedure . . . use waterless alcohol-based hand sanitizer or soap and water to clean their hands . . . When entering patient room . . . If gloves are used to perform a . . . procedure, hand hygiene must be completed before donning [applying] gloves . . . After removing gloves regardless of task completed . . . When moving from contaminated body site to a clean body site during patient care . . . When exiting patient room. . . ." Review of the facility policy titled "Standard, Enhanced Barrier, and Transmission Based Precautions" occurred on 09/11/25. This policy, dated July 2025, stated, ". . . Enhanced barrier precautions expand the use of personal protective equipment [PPE] . . . and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multi-drug-resistant organisms (MDROs) to staff hands and clothing. . . . Enhanced barrier precautions are also used for residents with chronic wounds . . . and residents with indwelling urinary catheters . . . High -contact resident care activities include transfers, dressing, providing hygiene, changing briefs or assisting with toileting . . . changing linens, indwelling medical device care or use . . . and wound care. . . ." -Observation on 09/09/25 at 3:45 p.m. showed Resident #4 ambulating down the hallway with their pants and brief sliding down. A certified nurse aide (CNA) (#3) placed an ungloved hand between the resident's skin and	F0880		

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F0880 SS = E	Continued from page 23 brief and pulled the brief/pants up. Without performing hand hygiene, the CNA sat in a chair and began typing on a computer. - Observation on 09/09/25 at 9:52 a.m. showed CNA (#3) entered Resident #5's room to assist with toileting. Without performing hand hygiene, the CNA applied gloves and transferred the resident to the toilet. The CNA removed the gloves, applied new gloves, completed perineal cares, applied a clean brief, and pulled up the resident's pants. The CNA removed the soiled gloves and without performing hand hygiene, applied clean gloves and transferred the resident back into the wheelchair. The CNA (#3) removed the gloves and performed hand hygiene. The CNA (#3) failed to perform hand hygiene after removing the soiled gloves and applying clean gloves. - Observation on 09/09/25 at 1:41 p.m., showed two CNAs (#2 and #3) entered Resident #19's room to provide incontinence cares. The CNA (#3) failed to perform hand hygiene before entering the room. After completing incontinence cares, the CNA (#3) removed the soiled gloves, bagged the soiled linen and exited the room. The CNA (#3) failed to perform hand hygiene and exited the room. The CNA (#2) removed the soiled gloves, removed the wheelchair from the room, reentered the room and performed hand hygiene. -Review of Resident #22's medical record occurred on all days of survey. The current care plan stated, ". . . The resident requires Enhanced Barrier Precautions (EBP) R/T [related to] indwelling medical device-catheter . . . Don [apply] gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing, device care and/or use, and wound care. . . ." Observation on 09/11/2025 at 5:35 a.m. showed a CNA (#13) entered Resident #22's room without performing hand hygiene and without applying a gown. The CNA applied gloves and assisted the resident to the toilet. At 5:55 a.m., a nurse (#14) entered Resident #22's bathroom without applying a gown to assist the CNA (#13) with perineal cares and transfer back into the wheelchair. Without performing hand hygiene, the nurse removed gloves from their pocket, completed the resident's perineal cares, pulled the resident's pants up, and assisted the CNA (#13) to transfer the resident back into the wheelchair. The CNA and the nurse then removed their gloves and performed hand hygiene.	F0880		

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F0880 SS = E	Continued from page 24 The CNA (#13) and the nurse (#14) failed to apply gowns before completing high contact cares and failed to perform hand hygiene after perineal cares. -Review of Resident #26's medical record occurred on all days of survey. The current care plan stated, ". . . The resident requires Enhanced Barrier Precautions R/T open wound . . . Don [apply] gown and gloves when performing high contact care activities including . . . checking and changing . . .” Observations of Resident #26 showed the following: *09/08/25 at 3:51 p.m., two CNAs (#16 and #17) applied gowns, and without performing hand hygiene, applied gloves, entered the resident's room, and provided incontinent cares. During cares, the CNA (#16) discarded a soiled brief and soiled gloves into the trash can and without performing hand hygiene, obtained gloves from their own pocket, applied the gloves, and transferred the resident with a hoyer lift. *09/09/25 at 1:23 p.m., Two CNAs (#2 and #3) performed hand hygiene, applied gloves, failed to apply gowns, and provided incontinent cares for the resident. During cares, the CNA (#2) removed one glove and asked the CNA (#3) for a clean glove. The CNA (#3) removed a handful of gloves from their pocket, which fell onto the resident's bed. The CNA (#2) picked up one glove from the bed and applied without performing hand hygiene. The CNA (#3) picked up the remaining gloves from the resident's bed and placed them back into her pocket. The CNAs (#2, #3, #16, and #17) failed to perform hand hygiene between glove changes, apply clean gloves, and apply gowns before completing Resident #26's cares. -Observation on 09/08/25 at 4:15 p.m. showed a CNA (#3) applied gloves without performing hand hygiene and transferred Resident #34 from a wheelchair to the toilet utilizing a sit to stand lift. The CNA removed the resident's soiled brief, placed the brief into a trash can, and lowered the resident onto the toilet. The CNA (#3) removed her gloves, and without performing hand hygiene, applied clean gloves, removed the trash bag from the can, and removed her gloves. Without performing hand hygiene, the CNA applied clean gloves, performed perineal cares, applied a clean brief, pulled up the resident's pants, removed her gloves and transferred the resident back into the wheelchair. The CNA removed the lift sling, straightened the resident's clothing, and exited the room with the lift. The CNA (#3) returned to the resident's room, carried the trash	F0880		

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F0880 SS = E	Continued from page 25 bag to a soiled utility room down the hallway, and then performed hand hygiene. The CNA (#3) failed to perform hand hygiene between glove changes, after completing perineal cares, before moving on to other tasks, and before exiting the resident's room. - Observation on 09/11/25 at 7:33 a.m. showed a medication aide (MA) (#7) entered Resident #40's room with medications. The resident was in the bathroom at the time, so the MA applied gloves, removed the soiled linen and garbage room the room, and placed them in the soiled utility room. The MA (#7) returned to the room and failed to perform hand hygiene. -Observation on 09/09/25 at 8:17 a.m. showed a CNA (#12) transferred Resident #48 into the bathroom. Without performing hand hygiene, the CNA (#12), applied gloves, removed resident's soiled shirt and soiled brief, and performed perineal cares. Without removing her soiled gloves, the CNA applied a clean brief, removed the resident's soiled shoes, socks, and pants, cleansed the resident's legs, and then removed the soiled gloves. Without performing hand hygiene, the CNA applied new gloves and dressed the resident. During an interview on 9/11/25 at 10:45 am, an administrative staff member (#1) stated she expected staff to perform hand hygiene before entering and exiting resident rooms, between glove changes, after resident cares, and apply gowns/gloves when providing high contact cares for residents on EBP.	F0880		
F0921 SS = D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility policy, and resident and staff interviews, the facility failed to provide a safe, sanitary, and comfortable environment for 2 of 18 sampled residents (Resident #5 and #26), and 2 of 5 supplemental residents (Resident #14 and #19). Failure to ensure residents' fans, walls, and wheelchairs are clean, and failure to remove non-working refrigerators in resident rooms may affect	F0921	1)Upon discovery on 9/11/25: the non-functioning personal refrigerator was removed from resident #14 / resident #19 room, resident # 26 fan was cleaned, resident #26 wall was cleaned, resident #5 and resident #6 wheelchair / wheelchair cushion was cleaned and resident #6 clothing removed from floor and taken to laundry. 2)All residents have the potential to be affected by these deficient practices. Environmental services director checked all personal resident refrigerators and found to be functioning and cleaned all fans in resident rooms. 3)Education provided to all staff by administrator or designee on the facility responsibility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public, specific to	10/10/2025

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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
F0921 SS = D	Continued from page 26 the well-being, comfort, health, and safety of the residents. Findings include: Review of the facility policy titled "Housekeeping, Standard or Light Cleaning" occurred on 09/11/25. This policy, dated 08/21/25, stated, ". . . PURPOSE To provide procedures for the proper, daily cleaning of resident rooms . . . thorough, routine, and high-quality cleaning procedures are necessary to minimize the prevalence of infection. . . ." Review of the facility policy titled "Standard, Enhanced Barrier, and Transmission-Based Precautions" occurred on 09/11/25. This policy, dated 07/07/25, stated, ". . . Standard precautions are based on the principle that all . . . body fluids, secretions, . . . may contain transmissible infectious agents. . . . " Observations on all days of survey showed a thick layer of dust on the personal fan in Resident #26's room and an unidentified brown substance on the wall beside the resident's bed. During an interview on 09/08/25 at 1:08 p.m., Resident #26 stated he could not use the bed pan for bowel movements, "I blew it all over, look at the wall it's still on there." - Observation on all days of survey showed a refrigerator located in Resident #14 and #19's room. The refrigerator emitted a strong foul odor. The thermometer in the refrigerator read 78 degrees Fahrenheit. Both residents stated it was not their refrigerator, and Resident #19 stated, "It was my prior roommates." - Observation on 09/09/25 at 9:52 a.m. showed food crumbs on Resident #5's wheelchair. A certified nurse aide (CNA) (#3) assisted the resident from the toilet, and without cleaning the cushion placed the resident back in the soiled wheelchair. -Observation of Resident #6's room on 09/09/25 at 10:00 a.m., showed crumbs covering the wheelchair seat pad and a shirt laying on the floor. During an interview on 09/11/25 at 1:40 p.m., two administrative staff members (#1 and #10) stated they expected staff to clean resident fans weekly, clean dirty walls, and remove nonfunctioning appliances immediately from resident rooms.	F0921	Continued from page 26 functioning personal resident refrigerator; clean fans, walls, wheelchairs/ wheelchair cushions and not placing resident clothing on floor. Staff educated by attending one of the all-staff meeting held on10/6/25 and 10/7/25 or prior to compliance date. New facility practice: The Environmental services director added fan cleaning to TELS to be completed monthly. Medication aide will check personal resident refrigerator temperature log / functionality daily. Wheelchair cleaning schedule implemented, with additional cleaning if visual signs of debris / soiling. 4) Environmental Services Director or Designee will conduct observation audits in each resident room to include visual inspection of fans, cleanliness of surfaces including walls, cleanliness of wheelchairs / wheelchair cushions and for presence of clothing / linens on floor. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months, then 1 X / quarter for 3 quarters. All audit findings will be submitted to the monthly QAPI Committee for review and recommendation. 5)Compliance Date: 10/10/2025	