STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	C 10/05/2023

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 The standard Medicare/Medicaid recertification survey and facility reported incident investigation started on 10/02/23 and concluded 10/05/23. The facility was found in compliance with regulatory requirements for the facility reported incident.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		10/27/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	C 10/05/2023

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 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and resident and staff interview, the facility failed to provide an environment that maintained, enhanced, and respected each resident's dignity and individuality on 1 of 4 days of survey (October 2, 2023). Failure to provide non-plastic silverware did not promote the residents' dignity or enhance their quality of life. Findings include: Review of the facility policy titled "Dignity in Dining" occurred on 10/04/23. This policy, dated 01/18/23, stated, ". . . Procedure: Employees promote resident independence and dignity in dining by: . . . Avoiding the use of plastic cutlery and paper or Styrofoam cups, plates, or bowls, as able. . . ." Observation on 10/02/23 at 12:20 p.m. showed Resident #4 and Resident #35 seated together at a dining room table. Resident #4 stated, "I want real silverware. I'm not at a picnic. I pay all this money to get plastic silverware." Resident #35 held up three plastic spoons and stated, "Look at this, what am I supposed to do with three	F 550	1. Administrator met with Resident #4 and #35 on 10/24/23 to communicate that Dietary Staff have been educated on proper use of plastic silverware, that plastic silverware will only be used in very specific situations and residents will be informed prior to use. Administrator educated dietary staff on 10/5/2023 regarding proper use of plastic silverware. 2.All residents have the potential to be affected by this deficient practice. 3.Additional silverware was purchased and put into use, to decrease the need to utilize plastic utensils. Dietary staff were re-educated by Administrator and Food / Nutrition Supervisor on Resident Rights, specific to treating resident with respect, dignity and caring for residents in a manner and environment that promotes, maintains, and enhances quality of life by avoiding the use of plastic silverware on 10/19/2023 or by next scheduled shift. Facility practice implemented that staff must get approval by Food / Nutrition	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	C 10/05/2023

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 550	Continued From page 2 spoons?" Observation on 10/02/23 at 12:25 p.m. showed all the residents in the dining room, except one with adaptive silverware, ate their lunch meal with plastic silverware. A dietary staff member (#2) stated they provided residents with plastic silverware because they are short a cook today. During an interview on 10/04/23 at 2:20 p.m., a dietary staff member (#2) stated, "It is not normal to use plastic silverware."	F 550	Manager or on call clinical leader to utilize plastic silverware. All staff were educated on Dining with Dignity Policy by DNS on 10/19/2023 or prior to the next scheduled shift. 4.The Food / Nutrition Manager or designee will conduct observation audits of the dining room to observe for use of plastic silverware. The audit will be completed for 3 meals / day for 2 weeks, then 3 meals on 3 days/ week for 2 weeks, then 3 meals on 6 random days / month for 2 months. Any deficient practice will be immediately addressed. All audit results will be submitted to the monthly QAPI committee for review and recommendations.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's	F 640		10/27/23

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 _____	C 10/05/2023

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 640	Continued From page 3 assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. 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 (Version 1.17.1), and staff interview, the facility failed to ensure timely electronic data submission of required Minimum Data Set (MDS) discharge	F 640	1. Upon discovery resident 42's MDS was submitted to CMS on 10/5/2023. 2. All residents have the potential to be affected by this deficient practice. MDS transmission audit completed for last 12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	C 10/05/2023

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 640	Continued From page 4 assessments for 1 supplemental resident (Resident #42). Failure to follow the MDS data submission specifications does not meet the intended regulatory requirements. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual, revised October 2019, page 2-37, stated, "Discharge Assessment-Return Not Anticipated . . . Must be submitted within 14 days after the MDS completion date. . . ." Review of Resident #42's medical record occurred on 10/05/23. The MDS showed a discharge date of 06/26/23 for Resident #42. At 10:27 a.m. on 10/05/23, an administrative nurse (#1) reviewed validation reports and confirmed the Center for Medicare and Medicaid Services (CMS) did not receive the above discharge assessment. The facility failed to submit the discharge assessment to CMS.	F 640	months, 1 resident CMS and State MDS was to be transmitted on 10/19/23 and was transmitted upon discovery on 10/23/23. 3. MDS coordinator re-educated by GSS Senior Clinical Reimbursement RN on 10/23/23 on GSS MDS Policy and Procedure, specific to transmission of MDS and processing validation reports. MDS Coordinator, Health Information Manager (HIM), and Business Office Manager (BOM) educated on 10/24/23 by GSS Regional Clinical Service Director RN on facility process: MDS Coordinator will transmit MDS's. The initial feedback report and state / CMS final validation reports will be reviewed / signed to ensure the assessments transmitted, accepted by the state, and note any errors that need to be corrected. 4. QAPI coordinator or designee will audit Final Transmission Reports for MDS acceptance, any noted errors with correction of applicable and MDs, HIM, and BOM signature. Audit will be completed on 100% final validation reports 1 time every 2 weeks X 2, then 1 time a Month X 2 months. Any deficient practice will be immediately addressed. All audit results will be submitted to the monthly QAPI committee for review and recommendations.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		10/27/23

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 _____	C 10/05/2023

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 658	Continued From page 5 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 record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of nursing practice for 1 of 2 sampled residents (Resident #29) receiving insulin. Failure to carry out a physician's order and document administration of medication as ordered may result in adverse health effects. Findings include: Review of the facility policy titled "Physician/Practitioner Orders - Rehab/Skilled" occurred on 10/05/23. This policy, dated 03/29/23, stated, ". . . An order is required to discontinue a current order. . . " Review of the facility policy titled "Medication: Insulin Administration, Insulin Pens - Rehab/Skilled & Long Term Care" occurred on 10/05/23. This policy, dated 04/26/23, stated, ". . . 11. Document dosage, time and site of injection on the MAR [medication administration record] or TAR [treatment administration record] . . . " Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., Massachusetts, page 63, stated, ". . . It is the nurse's responsibility to seek clarification of . . . orders from the prescriber . . . the nurse is responsible for carrying it out. . . ."	F 658	1. Upon discovery, charge nurse clarified resident #29 blood sugar monitoring is completed by Libre II sensor. Finger stick accu-check blood sugar is completed as per manufacturer instructions. Upon discovery on 10/4/23, DNS provided verbal re-education to on staff licensed nurses on documenting insulin administrations, refusals and blood sugar results. 2. All residents with an order for accu-checks and insulin have the potential to be affected by this deficient practice. Baseline documentation audit of October MAR / TAR conducted 10/25/23 for 5 residents receiving insulin and scheduled accu-checks. Missing documentation identified on one day, evening shift for 2 of 5 residents. Re-education to identified nurse provided by DNS on next scheduled shift. 3. All licensed nurses and medication aides were re-educated by DNS on the responsibility of accurate timely documentation to include resident refusals on 10/18/23 and 10/19/23 or prior to the next scheduled shift. 4. DNS or designee will audit MAR and TAR documentation on 100% residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	C 10/05/2023

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 658	Continued From page 6 Review of Resident #29's medical record occurred on all days of survey. Diagnoses included diabetes. The current physician's orders showed an order for Novolog sliding scale insulin to be administered three times a day before meals and "Accu check [sic] finger stick once daily before breakfast and verify it matches reading of continuous glucose monitor." A nurses note, dated 03/29/23 at 10:27 a.m., stated, ". . . Fax received regarding glucose finger sticks. MD [doctor] states 'please check manufacturers [sic] instructions. Some require/recommend fingersticks and some may not'. Ok to use as per manufacturer instruction." Review of the MAR/TARs dated March 1 through October 5, 2023, showed the facility failed to document administration or resident refusal of the Novolog sliding scale insulin 16 times. The medical record also lacked documentation of completion of accucheck finger stick before breakfast. During an interview on 10/04/23 at 9:50 a.m., a nurse (#5) confirmed the accucheck finger stick is not on the MAR/TAR and she does not complete it. During an interview on 10/04/23 at 1:40 p.m., an administrative nurse (#4) confirmed staff failed to document Resident #29's Novolog sliding scale insulin administration/refusal in the MAR/TAR and failed to obtain a physician's order to discontinue the accuchecks when manufacturer guidelines for the continuous glucose monitor were reviewed and indicated that daily	F 658	receiving insulin and accu-check blood sugar for complete documentation. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly 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 _____	C 10/05/2023

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 658	Continued From page 7 accuchecks were not recommended.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; 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 required assistance with activities of daily living (ADLs) for 2 of 9 sampled residents (Residents #2 and #17) and one supplemental resident (Resident #16). Failure to shave residents may result in poor personal hygiene and decreased self-esteem. Review of the facility policy titled "Activities of Daily Living" occurred on 10/04/23. This policy, dated 11/29/22, stated, ". . . Policy. Any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming, and personal and oral hygiene. . . . ADLs are those necessary tasks conducted in the normal course of a resident's daily life. Included in these are the following: General Personal, Daily Hygiene/Grooming: . . . shaving . . ." - Review of Resident #2's medical record occurred on all days of survey. The current care plan stated, ". . . The resident has an ADL self care performance deficit R/T [related to] mobility/endurance E/B [evidenced by] generalized weakness . . . PERSONAL HYGIENE: Resident requires assist of 1 staff . . .	F 677	1. Upon discovery, 10/17/23, Residents #2, #16, and # 17 were observed and found to be well groomed with no facility hair present. 2. All residents requiring assistance with ADL's have the potential to be affected by this deficient practice. 3. All staff were educated by DNS or designee by 10/19/2023 or by next shift on GSS Grooming with Dignity policy. Administrator educated facility leadership team on 10/23/23 regarding the facility leadership rounding responsibilities to include grooming observation of residents. 4. The Administrator or designee will conduct resident observation audits and review leadership rounding forms 1 X / week for 4 weeks, then 1 X / month for 2 months. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations.	10/27/23

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 _____	C 10/05/2023

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 677	Continued From page 8	F 677		

"

Observations on all days of survey showed Resident #2 with visible facial hair on the chin.

- Review of Resident #16's medical record occurred on all days of survey. The current care plan stated, ". . . The resident has an ADL self care performance deficit R/T pain, . . . weakness, limited vision E/B unable to care for self . . . PERSONAL HYGIENE: Resident requires assist of 1 staff . . . "

Observations on all days of survey showed Resident #16 with visible facial hair on the chin and upper lip.

- Review of Resident #17's medical record occurred on all days of survey. The current care plan stated, ". . . The resident has an ADL self-care performance deficit R/T Alzheimer's/epilepsy E/B confusion. . . . PERSONAL HYGIENE: Resident requires x1 staff assist. . . . Resident's family prefers staff to shave him in the AM [morning] as he allows . . ."

During an observation on 10/03/23 at 10:00 a.m., two certified nurse aides (CNA) (#6 and #7) assisted the resident with toileting. When asked when residents are shaved, the CNA (#6) stated, "They do that on bath day and [Resident #17] is scheduled for today on the evening shift." A review of Resident #17's bathing record showed the resident had a tub bath on 10/02/23 at 10:03 p.m.

Observations on all days of survey showed Resident #17 unshaven, with thick facial hair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	C 10/05/2023

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 677	Continued From page 9 During an interview on 10/04/23 at 11:50 a.m., an administrative nurse (#4) stated she expects residents to be shaved per policy or refusals to be documented.	F 677		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/24/23. Based on review of nurse staffing schedules and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day, seven days a week, for 2 of 96 days reviewed (07/22/23 and 09/10/23). Failure to ensure sufficient, qualified nursing staff are available eight consecutive hours a day has the potential to affect the health and safety of all the residents residing in the facility.	F 727	1.Facility initiated a Clinical RN on call schedule 10/1/23. The Clinical RN on call will be responsible for working as the 8-hour RN, when no other RN staff is available. 2.All residents have the potential to be affected by this deficient practice. 3.Facility will continue to advertise for open RN positions. Reeducation to Administrator, Nurse Leader and scheduler on RN staff requirement and	10/27/23

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 _____	C 10/05/2023

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 727	Continued From page 10 Findings include: On 10/04/23, the facility provided a copy of the nurse staffing schedules for the period of July 1 - October 4, 2023. A review of the schedules showed the facility failed to have the required RN coverage on 07/22/23 and 09/10/23. During an interview on 10/04/23 at 2:44 p.m., an administrative staff member (#2) confirmed the facility lacked RN coverage on the above dates.	F 727	facility system of communication: if RN coverage is not available, scheduler or charge nurse to notify DNS or on call Clinical RN. Education provided by GSS RCSD RN on 10/24/2023. Facility will utilize the clinical nurse on call to provide RN coverage when there is a call off. 4.The Administrator or designee will audit RN timecards for 8 hour/day RN coverage 7 days a week. Audit will be completed 1x/week for 4 weeks, then 1x/month for 2 months, then quarterly x 1. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI committee for review and recommendations.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 1 of 5 residents (Resident #39) observed during medication administration. Three medication errors occurred during staff administration of 40 medications, resulting in a 7% error rate. Failure to properly administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions.	F 759	1.Resident 39 had no negative outcomes related to medication error. Upon discovery, DNS clarified multi-vitamin order to include Brand Name of eye vitamin. Medication aide was reeducated by Director of Nursing on 10/4/2023 relating to topical application and MDI. 2.All residents have the potential to be affected by this deficient practice.	10/27/23

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 _____	C 10/05/2023

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 759	Continued From page 11 Findings include: Review of facility policies occurred on 10/04/23. Policies reviewed as follows: * "Medication: Topical Application," dated 08/01/23, stated, ". . . Purpose: To relieve pain . . . to administer medication as ordered. . . ." * "Metered Dose Inhalers," dated 03/01/23, stated, "Policy: Metered Dose Inhalers must be administered in a safe and accurate manner. . . . Corticosteroids: NOTE: The patient should be encouraged to rinse the mouth following use to help prevent oropharyngeal fungal infections. . . ." * "Medication: Administration Including Scheduling and Medication Aides," dated 03/29/23, stated, "Purpose . . . to administer medications correctly and in a timely manner . . . Medications are administered to the resident according to the 'Six Rights.' . . . Procedure . . . Perform three checks: Read the label on the medication container and compare with the medication administration record (MAR) when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication. . . ." Review of Resident #39's medical record occurred on 10/03/23. Physician's orders included: * "Eye Multivitamin Capsule (Multiple Vitamins-Minerals) Give 1 tablet by mouth two times a day." * "Advair HFA [propellant] Inhalation Aerosol . . . 2 puffs, inhale orally two times a day. Rinse mouth after use."	F 759	3.All medication aides and licensed nurses were reeducated by Director of Nursing or designee by 10/19/2023 or next scheduled shift on GSS medication Administrator Policy and procedure specific to administer medication per physician's order, medication aides to ask for clarification from a licensed nurse for any unclear medication orders and seeking order clarification from provider if indicated, and Metered Dose Inhalers Policy specific that a mouth rinse is encouraged after use. All medication aides completed medication administration competency with CLDS (Clinical Learning and Development RN Specialist) on 10/23/23. 4.The DNS or designee will observe medication pass to include MDI and topical application administration. Observation audits for 1 nurse and 1 medication aide will be completed 1x/ week for 2 weeks, then every other week for 2 weeks, then 1x month for 2 months, then quarterly X 1. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI committee 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 _____	C 10/05/2023

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 759	Continued From page 12 * "Diclofenac Sodium External Gel [Anti-inflammatory] . . . Apply to Right shoulder topically two times a day for pain." Observation of medication administration on 10/03/23 at 9:05 a.m. showed a medication assistant (MA) (#8) prepared and administered a multivitamin with minerals tablet rather than an eye vitamin capsule, administered an Advair inhaler without having the resident rinse their mouth following, and applied the Diclofenac gel to both of the resident's shoulders and neck. The MA (#8) failed to administer Resident #39's medications as ordered. During an interview on 10/04/23 at 11:50 a.m., an administrative staff member (#4) stated she expects the MA to administer medications as ordered, or to seek clarification from the charge nurse if unclear about a medication.	F 759		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		10/27/23

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 _____	C 10/05/2023

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 812	Continued From page 13 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of the Food and Drug Administration (FDA) 2022 Food Code, and staff interview, the facility failed to store food under sanitary conditions in 1 of 1 kitchen. Failure to store food in a sanitary environment in the walk-in freezer has the potential to result in contamination of food and could result in a foodborne illness. Findings include: The 2022 Food Code, pages 81-82, stated, "3-305.11 Food Storage. . . . FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; . . . 3-305.12 Food Storage, Prohibited Areas. FOOD may not be stored: . . . (G) Under leaking water lines, including leaking automatic fire sprinkler heads, or under lines on which water has condensed; . . . or (I) Under other sources of contamination." Observation on 10/02/23 at 12:24 p.m. in the main kitchen showed the floor of the walk-in freezer icy and slippery when stepped on. A maintenance staff member (#6) stated he just scraped the ice off the floor, as the condenser dripped and water spilled on the floor. Observation showed a large amount of ice on the	F 812	1.Administrator has been working with GSS Construction Project Manager to obtain bids for repair / replacement walk in freezer. Upon discovery, 10/5/23, administrator contacted this individual to get update on bidding process for repair / replacement. Administrator educated dietary staff and posted signage to empty the drain tray placed under condenser daily to avoid spillage on 10/2/2023. Administrator and Food & Nutrition Manager reorganized walk-in freezer so no food items can be stored under the condenser on 10/17/2023. 2.All residents and staff have the potential to be affected by this deficient practice. No employee injuries or food related illnesses have occurred. 3 Refrigeration/Freezer Company will be contracted to replace or repair the walk in. Representative onsite visit to inspect, measure and give options on 10/18/2023. The facility dietary staff will continue to monitor walk-in freezer each shift to ensure no food storage under condenser and drainage tray is emptied until time walk in is replaced / repaired.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	C 10/05/2023

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 812	Continued From page 14 freezer's condenser, which drips into a large sheet pan on the shelf directly under the condenser. A dietary staff member (#7) stated they were told to empty the pan every two to three days, and agreed sometimes the pan overflowed. She stated the water started dripping more than one month ago. Observation showed chunks and layers of ice on the top of several closed boxes of food underneath the condenser. During an interview on 10/04/23 at 2:20 p.m., a dietary staff member (#3) stated staff should probably empty the pan under the condenser every night. During an interview on 10/05/23 at 11:45 a.m., an administrative staff member (#8) stated they identified the condenser ice buildup/leak problem the end of August, contacted a company for possible repair/replacement options, placed a pan under the condenser to collect the dripping water, and educated dietary staff to empty it. The administrative staff member stated she placed a sign on the door to the freezer on Monday (10/02/23). Observation showed the sign stated, "Cooks Please check tray and empty every day." Failure to empty the collection pan frequently to prevent spillage and failure to protect food items below the condenser from dripping water may lead to contamination of the food.	F 812	4.Administrator or designee will observe that no food boxes are placed under the condenser and drainage tray is emptied 1x/ week until walk-in is replaced. Any deficient practice identified will be immediately addressed. All the audit results will be submitted to the monthly QAPI committee for review and recommendations.	