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 _____	09/18/2024

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

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 09/16/24 and concluded on 09/18/24.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 13 sampled residents (Resident #11, #12, and #26). 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 K: SWALLOWING/NUTRITIONAL STATUS The Long-Term Care Facility RAI 3.0 User's Manual, revised October 2023, page K-11, stated, ". . . Coding Instructions Check all that apply. . . . K0520B, feeding tube - nasogastric or abdominal (PEG). . . ." - Review of Resident #26's medical record occurred on all days of survey. The quarterly	F 641	F641 Accuracy of Assessment 1.On 09/19/2024, GSS RN Regional Clinical Service Director re-educated the MDS Coordinator on accurate MDS coding and completion. Resident # 12 MDS was corrected on 9/18/2024 to include the use of an antipsychotic med; Resident #26 MDS was corrected on 9/18/2024 to state resident not on feeding tube and Resident #11 MDS was corrected on 10/02/2024 to include unhealed pressure ulcer and were transmitted and accepted. 2.Any resident has the potential to be affected by this deficient practice. 3.MDS Coordinator and Director of Food and Nutrition will be re-educated by GSS Senior Clinical Reimbursement Analyst on accurate MDS coding for Section K, M, & N through the MDS RAI Manual by 10/23/24. 4.DNS or designee will audit 3 completed MDS□s prior to transmission for accuracy of coding in section K, M, & N. Any incorrect coding identified will be	10/23/24

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

Electronically Signed | 10/09/2024

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F 641	Continued From page 1 MDS, dated 07/19/24, identified a feeding tube. Review of the physician's orders for the assessment period lacked evidence of a feeding tube. SECTION M: SKIN CONDITIONS The Long-Term Care Facility RAI 3.0 User's Manual, revised October 2023, pages M-5 and M-12/13, stated, "[M-5] . . . Coding Instructions Code based on the presence of any pressure ulcer/injury in the past 7 days. . . . Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. . . . [M-12/13] . . . Stage 2 Pressure Ulcer Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present an intact or open/ruptured blister. . . . Coding Instructions for . . . Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2. . . . Enter the number of these 2 pressure ulcers that were first noted at the time of admission/entry AND-for residents who are reentering the facility after a hospital stay, enter the number of Stage 2 pressure ulcers that were acquired during the hospitalization . . ." - Review of Resident #11's medical record occurred on all days of survey. The record showed the resident returned from the hospital on 08/08/24. Review of a nurses' note 08/09/24, stated, ". . . Blister to the left heal [sic] is just beginning, . . ." The quarterly MDS, dated 08/14/24, failed to identify an unhealed pressure ulcer.	F 641	immediately addressed. Audits will be completed 1x/week X 2, every other week X 2, Monthly X 2. Audit results will be submitted to QAPI Committee for review and recommendations and ongoing monitoring or changing of frequency.	

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F 641	Continued From page 2 SECTION N: MEDICATIONS The Long-Term Care Facility RAI 3.0 User's Manual, revised October 2023, pages N-13, stated, ". . . Review the resident's medication administration records to determine if the resident received an antipsychotic medication . . . Coding Instructions . . . Code 0, no: if antipsychotics were not received . . . Code 1, yes: if antipsychotics were received on a routine basis only . . ." - Review of Resident #12's medical record occurred on all days of survey. A physician's order dated 04/12/24 stated, "Seroquel [antipsychotic medication] Oral Tablet 100 MG [milligrams] Give 100 mg by mouth two times a day . . ." The quarterly MDS, dated 07/25/24, failed to reflect the resident's routine use of an antipsychotic medication. During an interview on 09/08/24 at 12:03 p.m., an administrative staff member (#1) confirmed Resident #11, #12, and #26's MDS assessments were coded incorrectly.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		10/23/24

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F 658	Continued From page 3 Based on observation, record review, facility policy review, and staff interview, the facility failed to follow professional standards of practice for 2 of 2 sampled residents (Resident #5 and #11) observed with an indwelling catheter. Failure to obtain physician orders for an indwelling catheter, catheter care, and/or maintenance of the catheter may result in an adverse consequence for residents. Findings include: Review of the facility policy titled "Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen" occurred on 09/18/24. This policy, dated 07/30/24, stated. ". . . Catheters will be inserted only with a physician's order and will include the type of catheter, size and balloon capacity for indwelling catheter. . . . Indwelling or retention catheters are changed only when necessary and are connected to a closed drainage system. All closed collection systems that become contaminated by inappropriate technique, leaks or other means are immediately replaced. They are also changed when a new catheter is inserted and at other times only when necessary due to encrustations or according to physician's orders. . . ." Review of the facility policy titled "Physician/Practitioner Orders" occurred on 09/18/24. This policy, dated 04/01/24, stated, " . . . The admitting orders are intended to provide guidance on appropriate resident care . . . Required orders on admission: . . . Treatments: a treatment order will include the supporting reason (diagnosis/problem) . . ."	F 658	F658 □ Professional Standards 1.Upon discovery, provider notified for resident #5 and #11. Order received for indwelling catheter with supporting diagnosis. 2.Any residents with indwelling urinary catheters have the potential to be affected by this deficient practice. 3.All licensed nurses were re-educated by DNS or designee on GSS Policy and Procedures: Urinary Catheter and Physician/Practioner Orders, specific to order is required for urinary catheter use and supporting diagnosis. Education provided on 9/26/2024 or prior to next scheduled shift. 4.DNS or designee will conduct medical record audits on 100% of residents with urinary catheter to verify order and supporting diagnosis present. Any deficient practice identified, provider will be notified immediately for order/diagnosis clarification. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months. All audit results will be submitted to the monthly QAPI Committee for review and recommendations and ongoing monitoring or changing of frequency.	

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F 658	Continued From page 4 - Review of Resident #5's medical record occurred on all days of survey. The physician orders, dated 06/26/24, included placement of a foley (indwelling) catheter. Observation on all days of survey showed Resident #5 with an indwelling urinary catheter. The physician orders lacked instructions for catheter changes and/or care and maintenance of the indwelling catheter. During an interview on the morning of 09/18/24, an administrative staff member (#7) confirmed Resident #5's physician orders lacked instructions for the care and management for the indwelling catheter. - Review of Resident #11's medical record occurred on all day s of survey. Observations on September 16 and 17, 2024 showed Resident #11 with an indwelling urinary catheter. The physician orders lacked an order for the catheter, instruction for catheter changes and/or care and maintenance of the indwelling catheter. On the morning of 09/18/24, an administrative staff member (#7) confirmed the facility staff failed to transcribe Resident #11's physician orders for the indwelling catheter.	F 658		
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, review of manufacturer's	F 759	F759 □ Medication Errors	10/23/24

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F 759	Continued From page 5 instructions, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 3 of 5 residents (Resident #9, #17, and #25) observed during medication administration. Four medication errors occurred during staff administration of 25 medications, resulting in a 16 percent error rate. Failure to accurately prepare and administer medication may result in residents receiving an ineffective dose and/or experiencing adverse reactions. Findings include: Review of the manufacturer's package insert for Fiasp (fast acting insulin) FlexTouch Pen, dated October 2019, stated, "[Preparing Pen] . . . Step 4: Push the capped needle straight onto the Pen and twist the needle on until it is tight. Step 5: Pull off the needle cap. Do not throw it away. Step 6: Pull off the inner needle cap and throw it away. [Priming Pen] Step 7 Turn the dose selector to select 2 units . . . Step 9: Hold the pen with the needle pointing up. Press and hold in the dose button until the dose counter shows '0'. The '0' must line up with the dose pointer. A drop of insulin should be seen at the needle tip . . . [Select dose] . . . [Giving injection] . . . Step 13 Press and hold down the dose button until the dose counter shows '0' . . . Keep the needle in your skin after the dose counter has returned to '0' and slowly count to 6. When the does counter returns to '0', you will not get your full dose until 6 seconds later. . . ." Observations of Fiasp insulin administration for Resident #25: - On 09/17/24 at 4:42 p.m. showed a nurse (#3) primed the insulin pen with the needle cap on	F 759	1.Upon discovery on 9/19/24, Medication Aide was educated by GSS RN Regional Clinical Services Director on proper procedure of diluting / dissolving powered laxative (polyethylene glycol) as per label instructions. Upon discovery on 9/19/24, RN and Medication Aide were re-educated by GSS RN Regional Clinical Services Director on correct procedure for priming insulin pen and administrator, specific to post injection wait time of 6 seconds before removing needle. 2.Any resident receiving powered laxative or insulin pen administration have the potential to be affected by this deficient practice. 3.All medication aides and licensed nurses were re-educated on GSS Policy and Procedures: Medication Administration and Insulin Administration, specific to administering medication according to the label, to seek order clarification from provider if indicated, and correct procedure for priming insulin by holding insulin pen upward and post injection wait time of 6 seconds before removing needle. System changes: All med carts are now supplied with 7 oz size cups for diluting powered laxative and instructions for insulin pen priming and administration posted on medication carts. Education provided by (who) on (date) or prior to next scheduled shift. 4.The DNS or designee will observe medication pass to include powder laxative administration to verify correct amount of dilutant use and powder	

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F 759	Continued From page 6 and pointed down. The nurse (#3) failed to prime the pen with the cap off and the needle pointed up. - On 09/18/24 at 11:49 a.m. showed a nurse (#4) turned the dose selector to 6 units as ordered, attached the needle, and without priming the insulin pen administered the insulin, and removed the pen immediately from the resident's skin. The nurse (#4) failed to correctly attach the needle, prime the pen, and keep the needle in the skin for the recommended amount of time. Manufacturer's directions for polyethylene glycol (a powdered laxative) located on the medication bottle, stated, "Directions . . . fill to the top of the bottle cap which will provide the correct dose (17 g [grams]), stir and dissolve in any 4 to 8 ounces of beverage . . . then drink . . ." Observations on 09/18/24: - At 7:49 a.m., showed a medication aide (MA) (#5) placed 17 g of polyethylene glycol in a cup, added two to three ounces of water, and stirred. After Resident #9 drank the liquid, residue from the medication remained on the inside of the cup. - At 8:02 a.m., showed the MA (#5) placed 17 g of polyethylene glycol in a cup, added two to three ounces of water, and stirred. The MA (#5) held the cup so Resident #17 could drink the medication through a straw. The resident left half to one ounce of medication, not fully dissolved, in the cup. The MA (#5) failed to use the recommended amount of water to dissolve the ordered dose of polyethylene glycol. During an interview on 09/18/24 at 12:13 p.m., three administrative staff members (#6, #7, and #8) confirmed facility staff failed to administer	F 759	dissolved prior to administration.. Observation audits for 1 nurse and 1 medication aide will be completed 1 X / week for 2 weeks, then every other week for 2 weeks, then 1 X / month for 2 months. DNS or designee will conduct observation audits on 2 nurses / medication aides administering insulin to verify correct priming procedure and post administration wait time. Audits will be completed 3X/week for 4 weeks, then 1X/week for 4 weeks, then 1X/month for 1 month. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee for review and recommendations and ongoing monitoring or changing of frequency.	

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F 759	Continued From page 7 medications according to manufacturer's recommendations.	F 759		
F 880 SS=D	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 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	F 880		10/23/24

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F 880	Continued From page 8 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. 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, facility policy review, and professional reference, the facility failed to follow standards of infection control for 2 of 2 sampled residents (Resident #5,	F 880	F880 Infection Control 1.Nursing staff were re-educated of appropriate hand hygiene, glove use and	

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F 880	Continued From page 9 and #11) observed during catheter cares. Failure to follow infection control practices during resident cares related to hand hygiene, glove use, emptying urine container, and enhanced barrier precautions (EBP), has the potential to spread infection throughout the facility. Findings include: Review of facility policy titled "Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen" occurred on 09/18/24. This policy, dated 07/30/24, stated. ". . . Catheter Drainage Bag Emptying clinical skill check list. . . perform hand hygiene. Apply gloves. . . . When emptying the catheter bag, place a fluid-impermeable pad beneath the measuring container and avoid placing the measuring container on the floor. . . . Wash and dry measuring container. . . . Remove gloves, perform hand hygiene, . . ." Review of facility policy titled "Standard and Transmission-Based Precautions" occurred on 09/18/24. This policy, dated 04/02/24, stated. ". . . Enhanced barrier precautions . . . refer to the use of gown and gloves during high-contact resident care activities . . . are needed for residents with . . . Indwelling Medical devices (. . .indwelling urinary catheters . . .). . . . High-Contact Resident Care Activities include: Transfers, . . . while assisting with transfers and mobility, . . ." Kozier & Etb's "Fundementals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Incl, New Jersey, 2021, pages 686-687, stated, "Skill 31.2 Applying and Removing Personal Protective Equipment	F 880	EBP beginning on 10/01/2024 then on 10/10/2024 re-educated on CNA #9, and #2 on GSS Catheter policy specific to emptying indwelling catheter and proper cleaning of urine container. 2.Any resident has the potential to be affected by this deficient practice. 3.All staff re-educated on infection control practices, specific to hand hygiene and glove use, and EBP, by DNS and Administrator with communication beginning immediately on 9/23/2024 and re-education on 09/30/2024 and 10/01/2024. System change: all rooms had new hand sanitizer dispensers installed in residents bathroom. All nursing staff re-educated on GSS Catheter policy specific to emptying indwelling catheter and proper cleaning of urine container. 4.Infection Preventionist or designee will conduct observation audits of 5 staff members verifying proper hand hygiene, glove use, and EBP practices and will conduct 5 audits of proper technique of emptying a catheter by staff. Audits will be completed 1x/week for 4 weeks, then 1x/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 recommendation.	

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F 880	Continued From page 10 (Gloves, Gown, Mask, Eyewear) . . . 3. Apply a clean gown. . . . Overlap the gown at the back as much as possible, and fasten the waist ties or belt. . . . 6. Apply clean gloves. . . ." - Review of Resident #5's medical record occurred on all days of survey. The care plan indicated EBP related to an indwelling urinary catheter. A supply cart and signage for EBP observed inside the resident's room. Observation on 09/16/24 at 1:17 p.m. showed a certified nurse aide (CNA) (#2) entered Resident #5's room. The CNA positioned Resident #5 next to the bed, reached under the resident's right arm, assisted the resident to a standing position from the wheelchair, and pivot transferred the resident onto the bed. The CNA lifted the resident's legs onto the bed and hung the urine collection bag onto the bed frame. The CNA (#2) donned a gown and gloves, emptied the urine collection bag into a measuring container, discarded the urine into the toilet, held the contaminated container under the sink faucet, of a shared bathroom, obtained water, rinsed, and emptied the contents of the container into the toilet. The CNA (#2) failed to donn a gown or gloves before assisting with a transfer, failed to perform hand hygiene prior to donning PPE, and held a contaminated urine container in the sink of a shared bathroom. - Review of Resident #11's medical record occurred on all days of survey. The care plan indicated EBP related to an indwelling urinary catheter. Signage for EBP was located on the	F 880		

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F 880	Continued From page 11 hallway door frame and a supply cart was in the resident's room. Observation on 09/17/24 at 9:07 a.m., showed a CNA (#9) assisted Resident #11 with a brief change. The CNA (#9) wore a gown and gloves, but failed to tie the gown at the waist. The untied gown kept falling into the workspace, and the CNA (#9) stopped cares, lifted her arms, and shrugged both shoulders, to get the gown out of the workspace. The CNA (#9) changed gloves without hand hygiene, obtained a measuring container and without a barrier placed the container on the floor. The CNA (#9) emptied most of the urine into the container, her gown falling forward, stood emptied the urine into the toilet, the gown wrapped around the front half of the toilet, repeated the process a second time to fully empty the urine collection bag, and without rinsing/cleansing the container put it away. The CNA (#9) removed her gown and gloves and without performing hand hygiene left the resident's room to obtain assistance. The CNAs (#9 and #10) entered the resident's room, CNA (#10) entered the bathroom, donned gloves, and returned to the door to don a gown. CNA (#9) donned a gown, tied it only at the neckline and entered the bathroom to don gloves. After the CNAs (#9 and #10) transferred Resident #11, CNA (#10) removed the gown/gloves and washed her hands. CNA (#9) changed gloves and without performing hand hygiene assisted Resident #11 with grooming and mouth care. CNA (#10) collected the garbage, started to disinfect the lift without gloves, stopped donned gloves, disinfected the lift, removed her gloves, and exited the room without performing hand hygiene. The CNAs failed to use PPE	F 880		

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 _____	09/18/2024

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 880	Continued From page 12 appropriately, one CNA (#9) failed to tie the gown at the waist and the other CNA (#10) failed to don the gown and then the gloves.	F 880		