STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 started on 02/14/22 and concluded 02/17/22.	F 000		
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: 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 2 of 3 sampled residents (Resident #13 and #23) with a history of falls with head injury. Failure to perform neurological assessments following an unwitnessed fall or fall with head injury has the potential to delay identification and treatment of signs/symptoms of a closed head injury. Findings include: Review of the facility policy titled "Neurological Evaluation-Rehab/Skilled" occurred on 02/17/22. This policy, revised 02/08/22, stated, ". . . To establish a baseline neurological status upon which subsequent evaluations may be compared and changes in neurological status may be determined . . . following an unwitnessed fall, following a resident event that results in a known or suspected head injury . . . After the completion of initial neurological evaluation with vital signs, continue with evaluations every 30 minutes x	F 658	1) In regards to residents #13, #23 and #16, the facility is unable to correct the missing assessments noted. 2) All residents have the potential to be affected by the same deficient practice. 3) Education to be provided by the Director of Nursing or designee to all nurses by March 24, 2022 on the automatic trigger of neurological assessments by the medical record software and the importance of completing them per policy, “Neurological Evaluation – Rehab Skilled.” Education also to be provided on the automatic trigger of the weekly skin assessment by the medical record software and the importance of completing them per policies, “Wound Documentation Workflow,” “Skin Assessment Pressure Ulcer Prevention and Documentation,” and “Wound Dressing Change – Rehab Skilled.” 4) The Director of Nursing or designee will perform an audit after each	3/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/10/2022

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F 658	Continued From page 1 [times] 4, then every eight hours x 3 days or as directed by the provider. . . ." - Review of Resident #13's medical record occurred on all days of survey. The current care plan identified, ". . . The resident has had an actual fall with minor injury, bump on his head R/T [related to] poor balance E/B [evidenced by] loss of balance. . . . Review as indicated for significant changes in cognition, safety awareness and decision-making capacity. . . ." The progress notes identified the following: * 03/18/21 at 11:50 p.m., "Resident had fall incident in room and sustained abrasion and raised area to posterior top of head. Area remains raised slightly soft and only tender to pressure. Abrasion area is dry and scabbed with no redness around. . . ." * 03/31/21 at 7:05 p.m., "Resident was found on the floor beside his bed, his head was leaning against his concentrator. [Resident #13] is confused at this time. . . . Full assessment has been completed at this time . . . Resident does not appear to have any physical injuries at this time. Resident fell weeks ago and still has a bump on his head and bruising throughout the body. Resident still has a black eye to the left from previous fall. . . ." Review of Resident #13's medical record identified facility staff failed to complete neurological assessments per facility policy. - Review of Resident #23's medical record occurred on all days of survey. The care plan identified, ". . . The resident is at risk for falls R/T gait/balance problems, E/B history of falls. . . .	F 658	unwitnessed fall or event that results in a known or suspected head injury. This audit will ensure the neurological checks are completed in the indicated time frames. This audit will be performed for every fall for three months and one fall per month for three months. The Director of Nursing or designee will also perform an audit for ensuring skin assessments are completed as indicated. This audit will be performed on a random three residents every week for two months, every two weeks for two months and every month for two months. The findings for all audits will be brought to the quality assurance committee at least monthly to ensure compliance and to resolve any adverse findings. 5) Corrective action will be completed by March 24, 2022.	

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F 658	Continued From page 2 Review as indicated for significant changes in cognition, safety awareness and decision-making capacity. . . ." The progress noted identified the following: * 11/10/21 at 12:14 p.m., "Writer was alerted . . . NP [nurse practitioner] . . . reported that resident had told him he leaned forward too much in his w/c [wheelchair] and tipped out. The scene supported this as well. . . . Assessment done . . . Right shoulder discomfort with movement; bump to right forehead. . . ." * 11/12/21 at 11:03 a.m., "[Resident #23] was resting with eyes closed in the recliner in the commons area. He was taken to his room for an assessment. . . . He does appear to have a sore a right arm and he [has] brusing [sic] to his face where he fell out of wheelchair." * 11/16/2021 at 4:46 p.m., "Charge Nurse was notified by [random resident] that [Resident #23] was on the floor . . . Resident was on the floor leaning on door . . . wheelchair was . . . 4 ft [feet] away from resident. Resident was assessed . . . " Review of Resident #23's medical record identified facility staff failed to complete neurological assessments per facility policy. During an interview on 02/17/22 at 10:30 a.m., a staff nurse (#3) reported, "We do neuro checks if there was an unwitnessed fall, a change in their cognitive state, if they hit their head, if there is an acute change in the mental state. The policy says we should do an initial one, then every 30 minutes times four, and then every eight hours times three days. They [nursing staff] definitely should do them [neuro checks] if there is a known head injury."	F 658		

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F 658	Continued From page 3 2. Based on record review, review of professional reference, and resident/staff interviews, the facility failed to follow professional standards of practice regarding physician's orders for 1 of 12 sampled resident (Resident #16) at risk for skin impairment. Failure to assess, monitor, and document skin observations may result in worsening signs/symptoms and/or delayed treatment for new skin impairment. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process, and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 64, states, ". . . Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." During an interview on 02/15/22 at 10:14 a.m. Resident #16 stated, "I often have bed sores on my butt, but the air mattress seems to help." Review of Resident #16's medical record occurred on all days of survey. A physician's order, dated 09/10/20 stated, "Weekly skin assessment every day shift every Sat [Saturday] for skin care." Review of the Weekly Skin Assessments dated October 2021 - February 2022 identified nursing staff failed to complete 7 of 19 weekly skin assessment. During an interview on 02/17/22 at 11:40 a.m., an	F 658		

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F 658	Continued From page 4 administrative staff member (#1) reported she expects nursing staff to carry out physician's orders as written.	F 658		
F 689 SS=D	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, policy review, and resident/staff interviews, the facility failed to provide adequate assistance for 2 of 4 sampled residents (Resident #7 and #23) observed during a sit-to-stand mechanical lift transfer. Failure to ensure proper use of the stand lift caused pain/discomfort and placed the residents at risk for additional pain and injury. Findings include: Review of the facility policy titled "Safe Resident Handling Program (SRHP) Resource Packet-Rehab/Skilled, Assisted Living" occurred on 02/17/22. This policy, revised 05/25/21, stated, ". . . Sit-to-Stand - For residents who demonstrate leg strength for weight bearing and are able to hold their torso in an upright position but are unable to pull themselves to a standing position. The resident must be able to bear weight on at least one leg, have some upper body strength and be cognitively able to follow	F 689	1) In regards to residents #7 and #23, a new nursing assessment will be completed by March 24, 2022 and the appropriate lift and sling will be used in the future and the residents care plans will also be updated. 2) All other residents who transfer using a mechanical lift have the potential to be affected by the same deficient practice. 3) Education will be provided to all nursing staff by the Director of Nursing or designee by March 24, 2022 to report any safety concerns while transferring a resident in a lift and the importance of completing the Sit-Stand-Walk Data Collection Tool in a timely manner and completing a new assessment when there are concerns. Education to be also be provided on Safe Resident Handling. 4) The Director of Nursing or designee will perform an audit on three random residents once per week for two months,	3/24/22

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F 689	Continued From page 5 cues and cooperate with procedure. . . ." - Review of Resident #7's medical record occurred on all days of survey and included a diagnosis of dementia. The current care plan stated, ". . . TRANSFER: Resident requires 1 staff assist, use standing lift medium harness and assist of one. . . ." Observations showed the following: * On 02/15/22 at 10:09 a.m., a certified nursing assistant (CNA) (#5) assisted Resident #7 from the wheelchair using the sit-to-stand lift. The CNA (#5) applied the safety harness and chest strap to the resident and lifted the resident onto the toilet. The resident did not bear weight and hung from the harness in a semi-seated position. * On 02/15/22 at 3:32 p.m., a CNA (#6) assisted Resident #7 out of the wheelchair using the sit-to-stand lift. The resident did not bear weight and hung from the harness in a semi-seated position. As the harness straps pulled upward into Resident #7's axillae, he groaned and his shoulders raised to ear level and elbows extended horizontally. - Review of Resident #23's medical record occurred on all days of survey. Diagnoses included dementia, osteitis (inflammation) of bone, and pain. The current care plan stated, ". . . The resident has an ADL [Activities of Daily Living] self-care performance deficit R/T [related to] activity intolerance E/B [evidenced by] tires quickly. . . . Resident is able to transfer with assist of 2 using the gait belt and walker. May use standing lift if resident is unable to stand or ambulate. . . ."	F 689	every two weeks for two months and every month for two months. This audit will ensure that proper lifts and slings are utilized based on observation and record review. The findings for all audits will be brought to the quality assurance committee at least monthly to ensure compliance and to resolve any adverse findings. 5) Corrective action will be completed by March 24, 2022.	

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F 689	Continued From page 6 Observation showed the following: * On 02/15/22 at 10:00 a.m. and 11:04 a.m., two CNAs (#7 and #8) transferred Resident #23 into the bathroom, then to bed, and later into his wheelchair utilizing the sit-to-stand lift. The resident did not bear weight and hung from the harness in a semi-seated position during the transfers. As the harness straps pulled upward into Resident #23's axillae, he groaned and his shoulders raised to ear level and elbows extended horizontally. * On 02/16/22 at 2:22 p.m., two CNAs (#7 and #9) transferred Resident #23 from his wheelchair into bed utilizing a sit-to-stand lift. The resident did not bear weight and hung from the harness in a semi-seated position. As the harness straps pulled upward into Resident #23's axillae, he groaned and his shoulders raised to ear level and elbows extended horizontally. Resident #23 stated, "I can't do it. I can't do it." The CNAs (#7 and #9) lowered him approximately six inches for him to sit on the edge of the bed. Neither CNA reported Resident #23's discomfort to the charge nurse. During an interview on 02/17/22 at 10:30 a.m., a staff nurse (#3) reported, "The residents have to bear weight. They shouldn't use one if they don't have leg strength, aren't able to ambulate safely by themselves, can't pivot, [and/or] can't follow commands." After discussing the observations identified above, the nurse (#3) stated, "In that case, we need to re-evaluate him [Resident #23] and they maybe should have used a Hoyer."	F 689		
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	F 727		3/24/22

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F 727	Continued From page 7 §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: Based on review of the nursing staff schedule, review of facility policy, and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day for 3 of 21 days reviewed (01/30/22, 02/12/22, and 02/13/22). Failure to ensure sufficient, qualified nursing staff are available on a daily basis has the potential to affect all the residents residing in the facility. Findings include: Review of the facility policy titled "Nursing Services Staff-Rehab/Skilled" occurred on 02/17/22. This policy, revised 05/27/21, stated, ". . . The location will use the services of a registered nurse for at least eight consecutive hours a day, seven days a week . . ." The facility provided a copy of the nurse's schedule for the time period of 01/30/22 to 02/19/22. A review of the schedule showed the	F 727	1) No residents were identified specifically in this deficiency, thus no corrective action can be accomplished on an individual basis. 2) All residents have the potential to be affected by this deficient practice. 3) Schedules will be planned in advance and available RNs will collaborate in order to ensure the facility has eight hours of consecutive RN coverage seven days a week. 4) The Director of Nursing or designee will perform an audit to ensure there are eight consecutive hours of RN coverage seven days a week. These audits will be performed weekly for two months, every two weeks for two months and monthly for two months. The findings for all audits will be brought to the quality assurance committee at least monthly to ensure compliance and to resolve any adverse findings.	

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F 727	Continued From page 8 facility lacked the required RN coverage on 01/30/22, 02/12/22, and 02/13/22. During an interview on 02/16/22 at 1:39 p.m., an administrative nurse (#1) confirmed the facility lacked eight consecutive hours of RN coverage on the days of 01/30/22, 02/12/22, and 02/13/22.	F 727	5) Corrective action will be completed by March 24, 2022.	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, review of resident council minutes, staff interview and sample meal trays, the facility failed to serve food that is palatable, safe and appetizing for 2 of 2 meals sampled (noon meals on February 15 and 16, 2021). Failure to serve meats that are easy to cut and chew may cause choking, decreased intake, weight loss, and inadequate nutrition. Findings include: Review of Resident Council meeting minutes from 08/31/21 to 01/25/22 occurred on 02/14/21 and identified monthly concerns related to the palatability of the meat. - The survey team received a test tray on	F 804	1) No residents were identified specifically in this deficiency, thus no corrective action can be accomplished on an individual basis. 2) All residents have the potential to be affected by this deficient practice. 3) Education will be provided by the Supervisor of Nutrition and Food Services or designee by March 24, 2022 to dietary staff on the proper preparation of meats, including cooking temperature and cutting processes. All meats shall be accompanied by a gravy or a sauce. Meat tenderizer will be added to any meats that may need it. The current tray serving cart will be replaced for a cart in the future that maintains proper temperature of the food	3/24/22

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F 804	Continued From page 9 02/15/22 at 11:59 a.m. The test tray from the main kitchen consisted of a chopped steak with gravy, baked potato, carrots, and diced peaches. Two surveyors identified the edges of the chopped steak as tough to cut and chew, but the center as tender. - A surveyor received a test tray on 02/16/22 at 12:08 p.m. The test tray from the main kitchen consisted of pork loin, fried potatoes, vegetable blend, and diced pears. The surveyor identified the pork loin was difficult to cut and chew. Surveyor findings of the test trays support the resident council minutes where five of the six months reviewed identified the meat as "tough," one specifying pork. During an interview on 2/17/22 at 11:30 a.m., a dietary staff member (#2) stated she expects staff to cook and cut meat to maintain its tenderness.	F 804	at all times. Food temperatures will continue to be taken during each meal as plates are served. A test tray at the end of service at least weekly will be temped to ensure the trays are staying to appropriate temperature until we are able to obtain a cart which keeps the trays warm at all times. 4) Audits checking that meats are tender and food is the proper temperature will be done three times weekly for two months, two times weekly for two months and weekly for two months. The Supervisor of Nutrition and Food Services or their designee will be responsible for the completion of the audits. The findings for all audits will be brought to the quality assurance committee at least monthly to ensure compliance and to resolve any adverse findings. 5) Corrective action will be completed by March 24, 2022.	
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.	F 812		3/24/22

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F 812	Continued From page 10 (iii) This provision does not preclude residents 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, professional reference, and staff interview, the facility failed to clean food preparation equipment in 1 of 1 kitchen. Failure to clean food preparation equipment between uses may result in the spread of illness and/or foodborne illness to residents, staff, and visitors. Findings include: The Food and Drug Administration (FDA) Food Code 2017, Page 142, states, ". . . EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. Observations showed the following: * 02/14/22 at 1:04 p.m., two toasters covered with breadcrumbs. * 02/16/22 at 10:20 p.m., two toasters covered with breadcrumbs, microwave turntable visibly soiled with grease , and a hotel pan (steam table pan) soiled with dirty water/meat juices in the oven. During an interview on 02/17/2 at 11:30 a.m., a dietary staff member (#2) agreed staff failed to	F 812	1) No residents were identified specifically in this deficiency, thus no corrective action can be accomplished on an individual basis. 2) All residents have the potential to be affected by this deficient practice. 3) Education will be provided by the Supervisor of Nutrition and Food Services or designee by March 24, 2022 to dietary staff on the importance of proper kitchen cleaning and cleaning schedules. 4) Audits checking that the kitchen is clean, including all equipment, will be done three times weekly for two months, two times weekly for two months and weekly for two months. The Supervisor of Nutrition and Food Services or their designee will be responsible for the completion of the audits. The findings for all audits will be brought to the quality assurance committee at least monthly to ensure compliance and to resolve any adverse findings. 5) Corrective action will be completed by March 24, 2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 11 clean the equipment.	F 812		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and policy review, the facility failed to maintain a working call system at each resident's bedside for 1 of 12 sampled residents (Resident #6). Failure to ensure residents have working call lights may result in the resident not able to call for assistance, including after a fall, an injury, or other medical condition. Findings include: Review of facility policy titled "Call Light" occurred on 02/17/22. This policy, dated 07/1/21, stated, "Purpose: To ensure resident always has a method of calling for assistance . . . When resident's call light is observed/heard, go to resident's room promptly. Respond to request as soon as possible. . . ." During an interview on 02/14/22 at 2:14 p.m., Resident #6 stated, "I don't have a call light. I don't need one." Observation of Resident #6's room on all four	F 919	1) Resident #29's (incorrectly identified as Resident #6 in 2567) call light cord was plugged back into the wall jack on February 17, 2022. The call was tested for functionality at that time and found to be in working order. Resident #29 was educated on February 17, 2022 on leaving the call light plugged in for his safety and not to cancel the call light on his own. 2) All other resident rooms will be checked to ensure call lights are plugged in and working properly. 3) Education will be provided by the Administrator or designee to all staff on the Call Light Policy. In addition, education will be provided to all staff that it is everyone's responsibility to ensure a resident has a call light within reach and it is in working order. A weekly task will be added in TELS for the Supervisor of Ancillary Services or designee to ensure the call lights are in working order. 4) Audits checking that all call lights are	3/24/22

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F 919	Continued From page 12 days of survey showed the call light cord unplugged from the call system jack next to the resident's bed. During an interview on 02/17/22 at 8:34 a.m., when asked why Resident #6 did not have a functioning call light, a nurse (#3) identified the resident had a call light, but it was unplugged from the wall jack, and stated she planned to inform maintenance.	F 919	within reach and in working order will be done weekly for three months, every two weeks for three months and monthly thereafter. The Supervisor of Ancillary Services or their designee will be responsible for the completion of the audits. An additional task will be placed on Resident #29's medical record so that the staff will check each shift that the call light is within reach and in working order. The findings for all audits will be brought to the quality assurance committee at least monthly to ensure compliance and to resolve any adverse findings. 5) Corrective action will be completed by March 24, 2022.	