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 _____	06/03/2025

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 survey started on 06/01/25 and concluded 06/03/25.	F 000		
F 641 SS=E	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- (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 observation, record review, review of	F 641	1. Resident #23 MDS from 5/6/25	7/7/25

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

Electronically Signed | 06/30/2025

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F 641	Continued From page 1 the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 5 of 13 sampled residents (Resident #2, #10, #23, #35, and #36). 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 GG: FUNCTIONAL ABILITIES AND GOALS The Long-Term Care Facility RAI Manual, revised October 2024, pages GG-5 to GG-8, stated, ". . . GG0115 Functional Limitation in Range of Motion: Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days. Coding: 0. No impairment, 1. Impairment on one side, 2. Impairment on both sides . . ." - Review of Resident #23's medical record occurred on all days of survey. The care plan stated, ". . . paralysis to upper extremities and right leg and needs assistance . . ." Observation on 06/02/25 at 10:19 a.m. showed Resident #23's bilateral arms/hands and bilateral legs limp/unable to move. A quarterly MDS, dated 05/06/25, failed to identify Resident #23's impairments to the upper and lower extremities.	F 641	modified to include impairment of extremities. Resident #10 MDS from 2/28/25 modified to include pressure prevention devices (roho cushion and pressure redistribution mattress) and correction of restraint coding d/t side rails used for positioning bars. Resident #2 MDS from 2/28/25 modified for correction related to no anticonvulsant medications administered, Resident #36 MDS from 5/13/25 modified related to cancer diagnosis, no anticonvulsant medication administered, and restraint coding d/t side rails used for positioning bars. Resident #35 MDS from 4/24/25 modified r/t anticonvulsant medication coding. 2. All residents have the potential to be affected by the deficient practice of incorrectly coding MDS. 3. MDS Coordinators will be re-educated on GSS MDS Policy and Procedure and RAI guidance specific to completion of sections GG, I, M, N and P by GSS Senior Reimbursement Analysis RN or designee by compliance date. New facility process: MDS nurses will double check each section for accuracy before signing and locking sections of MDS. 4. DNS or designee will audit 3 MDS sections GG, I, M, N and P for accuracy based on supporting documentation in the medical record. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months, then 1 X / quarter for 3 quarters. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly	

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F 641	Continued From page 2 During an interview on 06/03/25 at 09:18 a.m., an administrative nurse (#3) confirmed staff failed to code the MDS assessment correctly. SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2024, pages I-5 to I-8, stated, ". . . Active Diagnoses . . . Coding Instructions: Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status . . . medical treatments . . . during the 7-day look-back period . . ." - Review of Resident #36's medical record occurred on all days of survey. An admission provider's note, dated 05/07/25, identified a diagnosis of cancer. An admission MDS, dated 05/13/25, failed to identify an active diagnosis of cancer. SECTION M: SKIN CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2024, page M-37 to M-39, stated, ". . . Check all that apply in the last 7 days. . . . Coding Instructions: . . . . M1200A/M1200B pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer/injury. The appropriate pressure reducing device should be selected based on the individualized needs of the resident. . . ." Review of Resident #10's medical record occurred on days of survey. The care plan stated	F 641	QAPI Committee for review and recommendations.	

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F 641	Continued From page 3 "Roho [an alternating air cushion] cushion to wheelchair seat when up in chair." Observations on 06/03/25 at 8:24 a.m. and 1:29 p.m. showed a Roho cushion on Resident #10's wheelchair and a pressure relieving mattress to the bed. The annual MDS, dated 02/28/25, showed staff failed to code the use a Roho cushion and a pressure relieving mattress for Resident #10. SECTIONS N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2024, pages N-6 to N-8, stated, ". . . Code all high-risk drug class medications according to their pharmacological classification . . . N0415K1. Anticonvulsant: Check if an anticonvulsant medication was taken by the resident at any time during the 7-day observation period . . ." - Review of Resident #2's medical record occurred on all days of survey. A quarterly MDS, dated 02/28/25, showed facility staff coded anticonvulsant use during the seven-day assessment. The medical record failed to identify administration of an anticonvulsant medication during the assessment period. - Review of Resident #35's medical record occurred on all days of survey. A quarterly MDS, dated 04/24/25, showed facility staff coded anticonvulsant use during the assessment period. The medical record failed to identify an anticonvulsant medication administered in the look-back period.	F 641		

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F 641	Continued From page 4 - Review of Resident #36's medical record occurred on all days of survey. An admission MDS, dated 05/13/25, showed facility staff coded anticonvulsant use during the assessment period. The medical record failed to identify administration of an anticonvulsant medication during the assessment period. During an interview on 06/03/25 at 09:29 a.m., two administrative nurses (#3 and #4) confirmed staff failed to code the MDS assessments correctly. SECTION P: RESTRAINTS AND ALARMS The Long-Term Care Facility RAI User's Manual, revised October 2024, pages P1 to P5, stated, ". . . PHYSICAL RESTRAINTS: Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. . . . P0100: Physical Restraints . . . Coding Instructions: . . . After determining whether or not an item . . . is a physical restraint and was used during the 7-day look-back period, code the frequency of use: Code 0, not used: if the item was not used during the 7-day look-back or it was used but did not meet the definition. . . . Code 2, used daily: if the item met the definition and was used on a daily basis during the look-back period. . . ." - Review of Resident #10's medical record occurred on days of survey. The annual MDS, dated 02/28/25, showed facility staff coded bed rail used daily.	F 641		

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F 641	Continued From page 5 - Review of Resident #36's medical record occurred on all days of survey. A "Bed Rail Assessment", dated 05/07/25, stated, ". . . Would the side rail be considered a restraint? . . . 'No.' If no the side rails do not meet the definition of a restraint for this resident. . . ." An admission MDS, dated 05/13/25, showed facility staff coded bed rail as used daily. During an interview on 06/03/25 at 09:18 a.m., an administrative nurse (#3) confirmed the bed rails were not used as a restraint and facility staff coded the MDS's incorrectly.	F 641		
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 record review, review of facility policy, and staff interviews, the facility failed to provide the necessary services for 1 of 13 sampled residents (Resident #10) and 2 supplemental residents (#11 and #12) who required staff assistance with bathing. Failure to provide bathing as scheduled may result in poor personal hygiene and decreased self-esteem. Findings include: Review of the facility policy titled "Bathing" occurred on 06/03/25. This policy, dated September 2024, stated, "To promote cleanliness and general hygiene . . . To assist resident with	F 677	1. Nursing staff re-educated by DNS or designee on requirement to provide care as per care plan with complete documentation specific to bathing. If resident refuses, offer bath later in day or alternate type bathing. Report refusals to charge nurse and document. 2. All residents have the potential to be affected by this deficient practice. 3. All nursing staff will be re-educated on GSS Bathing and GSS Routine Practices Policy and Procedure, specific to providing bath as per resident care plan and resident choice with documentation, including documentation	7/7/25

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F 677	Continued From page 6 personal care . . ." During an interview on 6/02/25 at 8:28 a.m., a certified nurse aide (CNA) (#2), indicated he/she normally does baths, however, since the facility was working short staffed today he/she was working on the floor instead of giving resident baths. - Review of Resident #10's medical record occurred all days of survey. The care plan stated, ". . . BATHING: Resident requires assist of 1 with bathing in whirlpool. . . ." Review of the bathing record from May 5 through June 3, 2025, showed the facility staff failed to bathe the resident from May 19 to June 3, 2025, (15 days). - Review of Resident #11's medical record occurred on 06/03/25. The care plan stated, ". . . resident has an ADL [Activities of Daily Living] self care performance deficit. . . ." Review of bathing records from May 5 through June 3, 2025, showed the resident refused a bath on May 5, received a bath on May 12 and May 19. The facility failed to bathe the resident from May 20 to June 3 (15 days). - Review of Resident #12's medical record occurred on 06/03/25. The care plan stated, ". . . BATHING: Resident requires moderate assist of 1 staff with bathing. . . ." Review of bathing records from May 5 through June 3, 2025, showed the resident received a bath on May 5 and May 20, and refused a bath May 30. The facility failed to bathe the resident from May 6 to May 19 (13 days). During an interview on 06/03/25 at 6:40 p.m., an	F 677	of resident refusals. New facility process: bath aide will not be reassigned to CNA duties. CNA call offs will be covered by other licensed nurses or CNAs to meet resident needs. 4. DNS or designee will interview 5 residents for satisfaction with bathing and any other care needs and audit bathing documentation for 100% current residents. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months then 1 X / quarter for 3 quarters. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations.	

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F 677	Continued From page 7 administrative staff member (#1) confirmed Resident #10, #11 and #12's medical record lacked documentation staff provided bathing as scheduled.	F 677		
F 686 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 the necessary treatment and services to promote healing of a pressure ulcer for 1 of 2 sampled residents (Resident #10) with a pressure ulcer. Failure to provide wound treatment as ordered may result in delayed healing, wound infection, and worsening or development of a new pressure ulcer. Finding include: Review of the facility policy titled "Wound Dressing Change" occurred on 06/03/25. This policy, dated 11/01/24, stated, ". . . Check the	F 686	1. Licensed nurses received education by DNS on GSS Wound Dressing Change policy and procedure specific to providing care as per provider order. 2. All resident□s requiring dressing change have the potential to be affected by this deficient practice. 3. All licensed nurses will receive re-education by DNS on GSS Wound Dressing Change policy and procedure specific to following provider order, to date and initial dressing, and document dressing change on TAR or Wound Data Collection UDA. Education will be provided by compliance date. New facility	7/7/25

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F 686	Continued From page 8 physician's order . . . Identify date and initials on dressing/tape. . . . Chart dressing change . . ." Review of Resident #10's medical record occurred on all days of survey. A physician's order, dated 04/02/25, stated, "Decubitus Ulcer Coccyx [an open wound on or near the tailbone] Cleanse with Wound Cleanser, apply Collagen [a protein] Pad and cover with Bordered Gauze daily. every night shift for Decubitus Ulcer Coccyx." Observation on 06/03/25 at 8:24 a.m. showed two certified nurse aides (CNAs) (#8 and #9) assisted Resident #10 with a brief check and change. The dressing located on the resident's coccyx area showed a date of 05/31/25. During an interview on 06/03/25 at 10:50 a.m., a nurse (#10) stated the dressing is changed nightly and checked the treatment administration record (TAR). Documentation identified dressing changes completed on 05/31/25, twice on 06/01/25, and the resident refused on 06/02/25. Observation on 06/03/25 at 1:29 p.m. showed a nurse (#10) and the CNA (#8) completed a dressing change for Resident #10. The nurse (#10) confirmed the date written on the old dressing removed was 05/31/25. Review of the TAR for the month of May 2025 showed staff failed to complete/document dressing changes on 05/11/25, 05/20/25, and 05/24/25. The medical record did not indicate the resident refusal on these days.	F 686	process: charge nurse will make rounds end of each shift to ensure all dressing changes have been completed with nurse initials and date present. 4. DNS or designee will conduct observation audits of 2 residents requiring dressing change to ensure dressing is initialed and dated and documentation audit to ensure dressing change has been documented. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months then 1 X / quarter for 3 quarters. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		7/7/25

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F 690	Continued From page 9 §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 record review, review of facility policy,	F 690	1. CNAs re-educated by DNS or	

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F 690	Continued From page 10 and resident interview, the facility failed to provide necessary services and assistance for 1 of 1 confidential resident (Resident A) who voiced concerns related to toileting assistance. Failure to provide toileting assistance in a timely manner may result in a loss of dignity and placed the residents at risk for incontinence, skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and risk for fall and/or injuries. Findings include: Review of the facility policy titled "Bowel & Bladder" occurred on 06/03/25. This policy, dated May 2025, stated, ". . . PURPOSE To achieve a comfortable voiding schedule with the least amount of incontinent episodes . . ." Review of Resident A's medical record occurred on all days of survey. The care plan identified the following, ". . . TOILET USE: Resident requires 1 staff assist. . . ." The current Minimum Data Set, identified required substantial/maximal assist for toileting and always continent of bladder. During an interview on 06/01/25 at 4:21 p.m., Resident A stated he/she has been incontinent of urine due to waiting for staff assistance with toileting. The resident stated when he/she uses the call light for staff assistance it often takes 15-45 minutes. Review of Resident A's toileting log, dated May 4 through June 2, 2025, showed staff failed to toilet the resident for 4-11 hours on four occasions and resulted in urinary incontinence.	F 690	designee on providing care as per care plan specific to answering call lights and toileting residents. 2. All residents needing assistance with toileting have the potential to be affected by this deficient practice. 3. All staff will be re-educated by DNS or designee on the GSS Call Light Policy and Procedure, specific to all staff to answer call lights, assist if within their scope or stay with resident if needed for safety until appropriate staff arrives. Education will be provided by compliance date. All licensed nurses, CMAs, and CNAs re-educated by DNS or designee on providing care as per care plan, specific to toileting. New Facility Practice: Leadership rounding to assist with answering call lights and interviewing residents if care needs are being met. 4. DNS or designee will interview / observe 5 residents if toileting needs are being met and audit bowel and bladder documentation to ensure toileting is provided and documented as per care plan. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months then 1 X / quarter for 3 quarters. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations.	

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F 690	Continued From page 11 The facility staff failed to provide the necessary services and assistance for Resident A to maintain urinary continence.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and resident and staff interviews, the facility failed to provide respiratory care in accordance with professional standards and the plan of care for 1 of 1 sampled resident (Resident #25) with a diagnosis of severe obstructive sleep apnea. Failure to obtain or check on the status of a Continuous Positive Airway Pressure (CPAP) device may result in cardiovascular issues, daytime fatigue, impaired cognitive function and affect overall quality of life. Findings include: Review of the facility policy titled "Non - Invasive Respiratory Support" occurred on 06/03/25. This policy, dated October 2024, stated, ". . . PURPOSE . . . Provide the most effective treatment option . . . for those suffering with respiratory insufficiency. . . ."	F 695	1. Licensed nurses re-educated by DNS or designee on process of transcribing orders will follow up as indicated. 2. All residents have the potential to be affected by this deficient practice. 3. All licensed nurses will be re-educated by DNS or designee on GSS Provider Order Policy and Procedures, specific to verification order has been provided to respective supplier such as pharmacy, laboratory, durable medical equipment provider. Re-education will be provided by compliance date. New facility process: licensed nurse will review all orders written in the prior 24-hour to ensure order has been transcribed and processed. Any deficient practice identified will be addressed immediately. 4. DNS or designee will conduct documentation audit on 5 charts to ensure provider orders have been	7/7/25

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F 695	Continued From page 12 Review of Resident #25's medical record occurred on all days of survey and included diagnoses of severe sleep apnea and acute respiratory failure with hypoxia. During an interview on 06/01/25 at 4:41 p.m., Resident #25 stated, "I had a home sleep study in January and I'm supposed to have a CPAP, but they haven't gotten it for me yet." A home sleep test report, dated 02/22/25, identified Resident #25 had severe obstructive sleep apnea and indicated the need for a CPAP device. The medical record included an order request for a CPAP device to a medical equipment supplier on 02/27/25 and an order request to another medical equipment supplier on 05/23/25. During an interview on 06/03/25 at 2:38 p.m. an administrative staff member (#6) confirmed staff failed to order Resident #25's CPAP device until 05/23/25. The facility failed to follow up on obtaining a CPAP device for Resident #25 for over 3 months.	F 695	completed and the resident is receiving care as per order. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months then 1 X / quarter for 3 quarters. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours	F 732		7/7/25

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F 732	Continued From page 13 worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure posting of staff information on 2 of 3 days of survey (June 1-2, 2025). Failure to post staffing data does not allow residents and visitors information related to the number of licensed and unlicensed staff on duty each shift.	F 732	1. Updated Nurse Staffing Information was posted upon discovery. 2. All residents have the potential to be affected by this deficient practice. 3. Scheduler, QAPI Coordinator and all licensed nurses will be re-educated on GSS Nurse Staff Daily Posting Requirement Policy and Procedure,	

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F 732	Continued From page 14 Findings include: Review of the facility policy titled "Nursing Staff Daily Posting Requirements" occurred on 06/03/25. This policy, dated December 2024, stated, ". . . post daily the staffing and resident census at the beginning of each shift . . ." Observation on all days of survey showed a "Nurse Staffing Posting Information" form posted on a board in the hall by the residents' dining room. Review of the staffing information posted on 06/01/25 showed the data posted for 05/30/25. Review of the staffing information posted on 06/02/25 showed the data posted for the previous day. The facility failed to post current staffing information for June 1 and 2, 2025. During an interview on 06/03/25 at 6:40 p.m., an administrative staff member (#1) confirmed staff failed to post the appropriate staffing form for June 1-2, 2025.	F 732	specific to use of OnShift BIPPA report form, daily posting requirements with updates by GSS RCSD RN. Re-education will be provided by compliance date. New process: facility has identified primary and secondary employee responsible for the BIPPA forms, charge nurses will update with changes and DNS or designee will observe for accurate posting each business day. 4. DNS or designee will conduct observation audits for current / accurate posting 1 X / week for 4 weeks, then 1 X / month for 2 months then 1 X / quarter for 3 quarters. Any deficient practice identified will be addressed immediately. All audit results will be submitted to monthly QAPI Committee for review and recommendations.	
F 880 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	F 880		7/7/25

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F 880	Continued From page 15 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 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	F 880		

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F 880	Continued From page 16 (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, and review of facility policy, the facility failed to follow standards of infection control and prevention for 4 of 5 sampled residents (Resident #10 #23, #24, and #35) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions (EBP), perineal care, hand hygiene, and cleaning of a mechanical lift has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled " Standard, Enhanced Barrier, and Transmission-Based Precautions" occurred on 06/04/25. This policy, revised April 2025, stated, ". . . Enhanced barrier precautions expand the use of personal protective equipment [PPE] beyond situations in which exposure to blood or body fluids is anticipated and refer to the use of a gown and	F 880	1. Nursing staff were re-educated by DNS or designee on Enhanced Barrier Precautions specific to PPE use, hand hygiene, glove use, peri-care and cleaning of mechanical lifts after use. 2. All residents have the potential to be affected by this deficient practice. 3. All staff will be re-educated by DNS or designee on GSS Policy and Procedures: Standard, Enhanced Barrier, and Transmission-Based Precautions specific to proper PPE use, Hand Hygiene specific to hand hygiene and glove use / changes during all to include dressing change and peri-care, and Safe Resident Handling specific to cleaning lift after each use. Education will be provided by the compliance date. New facility process: DNS or designee will do weekly rounds observing cares and providing point in time re-education if needed.	

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F 880	Continued From page 17 gloves during high-contact resident care activities . . . Enhanced barrier precautions are also used for residents with chronic wounds (i.e., pressure ulcers . . .) . . . indwelling medical devices (i.e., indwelling urinary catheters, feeding tubes . . .) . . . High-contact resident care activities include transfers, dressings, assisting during bathing, providing hygiene, changing briefs or assisting with toileting . . ." Review of the facility policy titled " Hand Hygiene" occurred on 06/04/25. This policy, revised March 2022, stated, ". . . To establish hand hygiene as the single most important factor in preventing the spread of disease-causing organisms to patients . . . hand hygiene: a general term that applies to either handwashing or applying hand sanitizer . . . All employees will . . . adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene. 1. Entering Room, 2. Before Clean Task, 3. After Bodily fluid/Glove Removal, 4. Exiting Room, 5. Zones: Patient zone and Health-care zone . . ." Review of the facility policy titled " Environmental Cleaning Principles" occurred on 06/04/25. This undated policy, stated, ". . . Environmental cleaning plays an important role in an infection control program. . . . Multi-use equipment should be disinfected after use. . . ." - Review of Resident #10's medical record occurred all days of survey. The care plan stated, "The resident requires Enhanced Barrier Precautions [related to] open wound . . . [Apply] gown and gloves when performing high contact care activities including: . . . checking and changing . . . wound care."	F 880	4. DNS or designee will conduct observation audits of care provided by 3 nursing staff employees for infection control compliance during dressing change, peri-care and total lift transfers. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations.	

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F 880	Continued From page 18 During an observation on 06/03/25 at 8:24 a.m., two certified nursing assistants (CNAs) (#8 and #9) provided perineal cares for Resident #10. At 1:29 p.m., the CNA (#8) assisted with wound care. During both observations the CNAs failed to wear PPE prior to providing care to a Resident #10. - Review of Resident #23's medical record occurred on all days of survey. The current care plan stated, ". . . requires Enhanced Barrier Precautions (EBP) R/T [related to] indwelling medical device (feeding tube and catheter). . . ." Observation on 06/03/25 at 10:19 a.m. showed an EBP sign on Resident #23's door frame and a supply container outside the resident's room containing PPE. Two CNAs (#2 and #5) entered the room, performed hand hygiene, and applied gloves, but failed to wear gowns. The CNA (#5) obtained a wet wipe and cleansed the perineal area from back to front instead of front to back. The CNAs rolled the resident onto her left side and the CNA (#5) cleansed the rectal area, removed the soiled brief, and placed a clean brief under the resident. Without removing the soiled gloves, the CNA (#5) assisted the CNA (#2) with other personal cares. The CNA (#5) then removed the soiled gloves and without performing hand hygiene, obtained mouth swabs and mouthwash and completed oral cares. The CNA (#5) picked up soiled linen on the floor with ungloved hands and exited the room. The CNA (#5) failed to apply gloves and perform hand hygiene. The CNAs (#2 and #5) failed to apply gowns before providing cares. The CNA (#5) failed to	F 880		

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F 880	Continued From page 19	F 880		

provide appropriate incontinence cares, failed to remove soiled gloves and perform hand hygiene before applying clean gloves, handled soiled linen without gloves, and failed to perform hand hygiene before exiting Resident #23's room.

- Review of Resident #24's medical record occurred on all days of survey. The current care plan stated, ". . . has an ADL [activities of daily living] self care performance deficit R/T impaired cognition, mobility E/B [evidenced by] assist of 1-2 for cares . . . TOILETING USE: . . . requires assist of 2 and full lift. . . . has bladder incontinence R/T impaired cognition E/B urinary incontinence . . ."

Observation on 06/01/25 at 2:57 p.m. showed two CNAs (#7 and #8) entered Resident #24's room, performed hand hygiene, applied gloves and transferred the resident from the wheelchair to the bed with the full body mechanical lift. The CNA (#7) completed perineal cares, placed a new brief under the resident, and removed the soiled gloves. Without performing hand hygiene, the CNA (#7) completed personal cares for the resident. The CNA (#8) performed hand hygiene, exited the room with the mechanical lift, and placed it in the hallway. The CNA (#8) failed to sanitize the lift prior to exiting the resident's room.

- Review of Resident #35's medical record occurred on all days of survey. The current care plan stated, ". . . requires Enhanced Barrier Precautions (EBP) R/T indwelling medical device (Foley catheter) . . ."

Observation on 06/02/25 at 1:25 p.m. showed two CNAs (#2 and #5) entered the resident's

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F 880	Continued From page 20 room, performed hand hygiene, applied a gown and gloves and transferred the resident from the wheelchair to bed. The CNA (#5) performed catheter cares, cleansed the rectal area, discarded the soiled brief, and placed a clean brief under the resident. Without removing their soiled gloves and performing hand hygiene, the CNA (#5) completed other personal cares for the resident.	F 880		