

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355104		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2024	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - LAKOTA				STREET ADDRESS, CITY, STATE, ZIP CODE 608 4TH AVE SW LAKOTA, ND 58344			
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F 000	INITIAL COMMENTS			F 000			
F 580 SS=D	The standard Medicare/Medicaid recertification survey and complaint survey started on 06/17/24 and concluded 06/19/24. During the complaint investigation, the issues identified by the complainant were found in compliance. Notify of Changes (Injury/Denial/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment			F 580			7/25/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/19/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident's physician of a change in condition for 1 of 1 sampled resident (Resident #137) with missed blood tests. Failure to notify the physician of unsuccessful blood draws may have prevented the physician from altering the treatment/care provided to the resident. Findings include: Review of the facility policy titled "Notification of change" occurred on 06/19/24. This policy, reviewed 12/04/23, stated, ". . . A facility must immediately inform the resident, consult with the resident's physician, and notify, consistent with her or her authority, the resident representative(s) when there is . . . A need to	F 580	1) The provider overseeing Resident #137's care was notified on June 18, 2024, that she missed (2) two ordered blood draws / lab tests. 2) This deficient practice has the potential to affect all residents. 3) Re-education will be provided to facility licensed nurses and clinic nurses by GSS RN Regional Clinical Services Director or designee on completing blood draws by acting DNS on GSS Notification of Change Policy and Procedure, specific to missed laboratory tests as ordered. Training will be completed on July 25, 2024, or prior to the next scheduled shift. Facility implemented lab calendar book, night nurse will create list of residents / lab draws for next day for verification with		

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F 580	Continued From page 2 alter treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment. . . ." Review of Resident #137's medical record occurred on all days of survey. Diagnoses included chronic kidney disease. The physician's orders included a BMP [basic metabolic panel blood test] for 06/11/24 and 06/18/24. A hospital discharge summary , 05/27/24, stated, ". . . Monitor labs and electrolytes, frequently has Hypokalemia [low potassium]. . . ." A Progress note, dated 06/11/24 at 5:37 p.m., stated, "Lab draw this morning was unsuccessful, several staff attempted. Unable to find vein in upper extremities. . . ." The medical record lacked documentation the facility notified the provider regarding the missed BMPs on 06/11/24 and 06/18/24. During an interview on 06/19/24 12:55 p.m., an administrative nurse (#2) confirmed staff were unable to obtain blood samples on June 11th and 18th for the ordered lab work due to inability to find a vein. The administrative nurse stated the facility would notify the provider on next "rounds."	F 580	clinic nurse and day nurse will review lab results, reconciling with lab book, notify provider with documentation. Missed lab tests will be addressed immediately. 4) DNS or designee will conduct record review audits to verify proper notification of provider, specifically as relates to lab draws, results, and any missed tests. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee for review and recommendations 5) The corrective action will be completed by July 25, 2024.		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		7/25/24	

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F 623	Continued From page 3 language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;	F 623			

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F 623	Continued From page 4 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure	F 623			

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F 623	Continued From page 5 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the State Long Term Care Ombudsman a notice of transfer for 1 of 1 sampled resident (Resident #9) reviewed for hospital transfers. Failure to provide a copy of the transfer notice does not allow the ombudsman to be aware of facility practices regarding transfer and discharge or advocate on the resident's behalf. Findings include: Review of Resident #9's medical record occurred on all days of survey and identified hospital transfers on 01/21/24, 02/17/24, and 03/03/24. The resident's medical record lacked evidence the facility provided a copy of the transfer notices to the ombudsman. During an interview on the afternoon of 06/19/24, an administrative staff member (#5) confirmed the facility failed to send the notices to the ombudsman prior to 06/19/24.	F 623	1) The transfer/discharge forms for resident # 9's (3) three hospitalizations on 1/21/24, 2/17/24, and 3/3/24 were sent to the ombudsman on June 19, 2024. 2) This deficient practice has the potential to affect all residents. 3) RE-education provided to social service and licensed nurses by GSS RN Regional Clinical Services Director on GSS Transfer and Discharge Policy and Procedure specific to completion / issuance of ND specific transfer and discharge notification form and submission to ombudsman. This education will be provided by July 25, 2024, or prior to the next scheduled shift. 4) HIM Director or designee will conduct record review audit for the completion / issuance of ND notice of transfer / discharge form with submission to ombudsman. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee for review and recommendations		

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F 623	Continued From page 6	F 623	5) The corrective action will be completed by July 25, 2024.		7/25/24
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 2 of 12 sampled residents (Resident #2 and #9). 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: The Long-Term Care Facility RAI User's Manual, revised October 2023, page A-32, stated, ". . . A1500 . . . Code 1, yes: if PASRR [Preadmission Screening and Resident Review] Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. . . ." Page K-6 of the RAI manual stated, ". . . K0300 Weight Loss . . . Code 2, yes, not on physician-prescribed weight-loss regimen: if the	F 641	1) The three MDSs identified (Resident #2 - 4/26/24 and #9 □ 2/26/24 and 3/12/24) were modified to appropriately reflect the errors. The MDS for Resident #2 was modified for no weight loss on 6/21/24. Resident #9□s 3/12/24 MDS was modified on 7/10/24 to accurately reflect no weight loss. The MDS for Resident #9 dated 4/26/24 was modified to accurately reflect Level II on 6/18/24. 2) This deficient practice has the potential to affect all residents. 3) Education will be provided by GSS Senior Clinical Reimbursement Analyst to the MDS completion interdisciplinary team on accuracy of MDS completion on July 23, 2024. New Practice: all MDSs will be reviewed prior to submission by the interdisciplinary team to ensure accuracy. 4) The DNS or designee will conduct documentation review audits for MDS accuracy as relates to weight loss and PASRR screening level. Audits will be completed 1 X / week for 4 weeks, then 1X/ month for 2 months. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI		

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F 641	Continued From page 7 resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician. . . ." Section A: - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included schizoaffective disorder, bipolar type; generalized anxiety disorder; and personality disorder. A PASRR Level II Outcome, dated 12/06/23, stated, ". . . You fall in the category of having a diagnosis that the PASRR program was designed to assess. . . . That diagnosis is: A mental health condition. . . ." Resident #9's annual MDS, dated 02/26/24, identified a "no" response under Section A1500, "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?" During an interview on the afternoon of 06/18/24, a social services staff member (#1) confirmed facility staff coded Section A1500 incorrectly. Section K: -Review of Resident #2's medical record occurred on all days of survey. A significant change MDS, dated 04/26/24, identified weight loss; however, record review failed to identify Resident #2 experienced a 5% or more weight loss in 30 days or a 10% or more weight loss in 180 days.			F 641	Committee for review and recommendations 5) The corrective action will be completed by July 25, 2024.		

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F 641	Continued From page 8 - Review of Resident #9's medical record occurred on all days of survey. A quarterly MDS, dated 03/12/24, identified weight loss; however, record review failed to identify Resident #9 experienced a 5% or more weight loss in 30 days or a 10% or more weight loss in 180 days.	F 641			
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, review of facility policy, and staff and resident interview, the facility failed to provide care and services to maintain the resident's highest level of well-being for 1 of 1 sampled resident (Resident #30) with a change in health status followed by a transfer to the hospital. Failure to monitor and assess the resident's condition on an on-going basis resulted in worsening respiratory symptoms, a delay in treatment, and an admission to the hospital. Findings include: Review of the facility policy titled "Notification of Change" occurred on 06/19/24. This policy, dated 12/04/23, stated, ". . . A facility must immediately inform the resident, consult with the resident's	F 684	1) Memo re-education provided by acting DNS to licensed nurses on monitoring residents with change of condition, notification to provider with documentation. 2) All residents have the potential to be affected by the same deficient practice. 3) Re-education will be provided to all licensed nurses by GSS RN Regional Clinical Services Director on management of resident care, to include evaluation of resident condition with documentation, timely notification to provider with change of condition and resident's choice to not follow treatment plan, following provider orders, resident evaluation with documentation of pre and post PRN oxygen administration and repositioning		7/25/24

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F 684	Continued From page 9 physician . . . when there is: . . . A significant change in the resident's physical, mental or psychosocial status . . . A need to alter treatment significantly . . ." Observation on 06/17/24 at 11:12 a.m. showed Resident #30 ambulating in her room with oxygen in place via nasal cannula. The resident stated she was "good, except I can't breathe." The resident was noticeably short of breath and sat in her recliner. The surveyor asked if the resident would like a staff member to come in, and the resident stated, "No, they know," and indicated the doctor would be at the facility that day. The resident identified she has been feeling more short of breath and planned to speak with the doctor about it. Resident #30 stated she has needed increased oxygen "in the last five days or so," and was now receiving 3 liters per minute (lpm) of oxygen. The resident also stated she had blisters on her leg and thought they were infected. Observation on the morning of 06/18/24 showed Resident #30 in her recliner with oxygen via nasal cannula at 3 lpm. Resident #30 stated she was still experiencing shortness of breath, and the doctor did not come to see her yesterday. Resident #30 stated she was "very disappointed," but was told the doctor would be at the facility today (06/18/24). Review of Resident #30's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (COPD), pulmonary heart disease, and congestive heart failure. Current physician's orders included:	F 684	as per care plan. Education will be provided at facility all staff meeting on 07/25/24 or prior to next scheduled shift. HIM Director will track provider visits and report non-compliance to administrator. Clinical leadership team will meet each business day to provide oversight of management of resident's care, including change of condition . 4) DNS or designee will perform observation and documentation audits will be performed on (3) three random residents with changes in condition to verify documentation of resident evaluation and monitoring related to change, notification to provider, response to treatment changes if applicable, will observe (3) three random residents to verify repositioning / positioning are provided as per care plan, and will audit (3) three random residents with new provider orders to verify orders are transcribed properly, and care is being provided as per orders/care plans and if resident refusals are communicated to provider. Audits will be completed 1 X / day for 5 days, then 1 X / week for 3 weeks, then 1 X / month for 2 months. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee for review and recommendations 5) The corrective action will be completed by July 25, 2024.		

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F 684	Continued From page 10 *Supplemental oxygen (O2) at 2 lpm *Ventolin HFA (hydrofluoroalkane) (used to treat or prevent bronchospasms) Inhalation Aerosol Solution, 2 puffs inhale orally every 4 hours as needed for shortness of breath (SOB), wheezing. Resident #30's nurses' notes identified the following: *06/14/24 at 5:06 a.m.: ". . . Ventolin HFA Inhalation Aerosol Solution . . . 2 puff inhale orally every 4 hours as needed for SOB, wheezing. coughing with moist cough, inspiratory wheeze . . ." *06/14/24 5:23 a.m.: ". . . Ventolin HFA Inhalation . . . PRN [as needed] Administration was: Effective . . ." *06/14/24 at 8:15 p.m.: ". . . Entering resident's room and noted a dry hacky cough. She states that she has increased pain to the right mid back. With auscultation [sic] [listening to lung sounds with a stethoscope], noted moderately loud rhonchi [coarse, loud sounds caused by constricted airways] to all lobes on the right and the left was clear. Vitals taken and WNL [within normal limits]. noted that there are 5 intact fluid filled blisters to her RLL [right lower leg] and the left is more red. This was noted when taking off her thigh high ted hose. There was weeping fluid from an opened blister. Xeroform [a wound dressing] place [sic] and covered with gauze and kling [a type of gauze] until provider could be notified. Do [sic] review her weights and noted a 2.5# weight gain in a week and a 9# weight gain over the past month. Did request her ventolin [sic] inhaler to help her with her coughing and feeling winded. O2 is on a [sic] 2L/NC and sats are 96%. Wull [sic] continue to monitor and report to the oncoming shift to notify provider. . . ." The	F 684			

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F 684	Continued From page 11 record lacked evidence of physician notification. *06/15/24 at 4:19 p.m.: ". . . Ventolin HFA Inhalation Aerosol Solution . . . 2 puff inhale orally every 4 hours as needed for SOB, wheezing. CN [charge nurse] notified . . ." The record lacked evidence of a respiratory assessment or vital signs. *06/15/24 at 5:40 p.m.: ". . . Resident did not go to dining room for her supper because she stated she wasn't feeling well. She has rhonchi in right upper and lower lobes. SOB with any exertion. . . . left lower leg has erythema [redness] 10 x 9 cm [centimeters]. Has oxygen at 3 LPM NC due to increased SOB. Resting in recliner with legs elevated . . ." *06/15/24 at 8:54 p.m.: ". . . Ventolin HFA Inhalation Aerosol Solution . . . PRN Administration was: Effective no longer wheezing . . ." *06/15/24 at 9:20 p.m.: ". . . LATE ENTRY . . . States her cough is better tonight. Lung sounds are notably clearer with only a few rhonchi heard. Still turns O2 up to 3 liters with any activity and states this helps. . . ." *06/16/24 at 7:20 a.m.: ". . . Ventolin HFA Inhalation Aerosol Solution . . . 2 puff inhale orally every 4 hours as needed for SOB, wheezing. Per CN . . ." The record lacked evidence of a respiratory assessment or vital signs. *06/16/24 at 8:58 a.m.: ". . . Ventolin HFA Inhalation Aerosol Solution . . . PRN Administration was: Effective . . ." *06/16/24 at 3:32 p.m.: ". . . Right lower leg with 3 large fluid filled blisters and dark red around. Left leg is lighter red with no open areas. . . . She has expiratory wheezes throughout [sic] all posterior lung fields and left upper lobe. Also has rhonchi to left lower lobe anteriorly. Has had trays today			F 684			

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F 684	Continued From page 12 in room. . . . She is short of breath at rest. [Provider name] said she will see Resident tomorrow . . ." *06/16/24 at 8:42 p.m.: ". . . Ventolin HFA Inhalation Aerosol Solution . . . 2 puff inhale orally every 4 hours as needed for SOB, wheezing. . . ." The record lacked evidence of a respiratory assessment or vital signs. *06/17/24 at 12:00 a.m.: ". . . Wraps applied at HS [bedtime] tonight after dressing change because they measure bigger than the day shift. Still has a harsh cough but the ventalin [sic] helps her breath [sic]. 02 is on at 3L/nc [nasal cannula] because she feels she breathes better on this. Lung sound still have rhonchi and an audible wheeze noted with activity. Provider will be seeing her this afternoon she states . . ." *06/17/24 at 12:09 a.m.: ". . . Ventolin HFA Inhalation Aerosol Solution . . . PRN Administration was: Effective less coughing . . ." *06/17/24 at 4:34 p.m.: ". . . received order for Mucinex [used to loosen mucus in the airways and clear congestion] 600mg [milligrams] BID [twice a day] x 1 week. Will see resident at facility tomorrow. . . ." *06/17/24 at 9:48 p.m.: ". . . Ventolin HFA Inhalation Aerosol Solution . . . 2 puff inhale orally every 4 hours as needed for SOB, wheezing. . . ." The record lacked evidence of a respiratory assessment or vital signs. *06/17/24 at 10:51 p.m.: ". . . Ventolin HFA Inhalation Aerosol Solution . . . PRN Administration was: Effective . . ." *06/18/24 at 3:28 p.m.: ". . . late entry for 0930 today. This Resident was having difficulty breathing and had wheezes throughout all lung fields. Her lower legs and feet has [sic] 4 PE [pitting edema] and bright red. I asked her if she	F 684			

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F 684	Continued From page 13 wanted to go to the hospital and she said yes that she did. (11 [sic, 911] was called and the Lakota Ambulance was called and they arrived at 10:00 am and transported Resident to [hospital name] . . ." *06/18/24 at 3:55 p.m.: ". . . called [hospital name] and Resident was admitted to the hospital. . . ." The medication administration record (MAR) identified Resident #30 received five doses of PRN Ventolin from 06/14/24 to 06/17/24, and had not used the Ventolin prior to this during the month of June. The medical record and interview with Resident #30 identified increasing respiratory distress, pitting edema, lower leg blisters, weight gain, need for continuous oxygen at 3 lpm (versus 2 lpm as ordered), and use of PRN inhalers. The facility failed to report and act on Resident #30's complaints of respiratory distress and increased oxygen needs in a timely manner, assess and monitor the resident's respiratory status on an ongoing basis, and notify the medical provider until the afternoon of 06/16/24. These failures resulted in a delay in treatment and subsequent hospital admission. During an interview on the afternoon of 06/19/24, an administrative nurse (#2) stated staff should complete an assessment when they notice a change in condition. 2. Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure staff provided care and services for 2 of 12 sampled residents (Resident #1 and #16) care planned for a positioning device and physician	F 684			

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F 684	Continued From page 14 orders for devices for pain/swelling to an arm. Failure to apply a positioning device and to follow physician's orders for devices to control edema (swelling)/pain may result in poor posture, increased pain, worsening of edema, and other complications. Findings include: Review of the facility policy titled "Positioning" occurred on 06/19/24, This policy, dated 02/28/24, stated, "... Purpose: To provide proper body alignment for residents in wheelchairs. ... Position ... Resident is upright positioning and weight-bearing equally at hips (does not lean to one side). ..." - Review of Resident #1's medical record occurred on all days of survey and included a diagnosis of dementia and osteoporosis. The current care plan stated, "... The resident is at risk for falls R/T [related to] cognition deficit E/B [evidenced by] history of falls. ... Interventions: ... Resident is to use an Evolution chair/Broda chair [reclining wheelchair]. Does tend to slide down in chair, at times. Monitor for sliding in chair at all times. Monitor resident for significant changes in mobility, positioning device, sitting balance and lower extremity joint function. ..." Observations showed Resident #1 in a Broda wheelchair, with her body and head leaning to the left, and no positioning device present at the following times: *06/17/24 in the dining room at 12:02 p.m. in the TV room at 12:31 p.m. and in the dining room at 5:15 p.m. *06/18/24 in the TV room at 9:40 a.m. and 1:30			F 684			

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F 684	Continued From page 15 p.m. When asked if the resident had anything to keep her body and head upright, a certified nurse aide (CNA) (#7) stated, "No, but she should have something as she always leans to that [left] side". *06/18/24 at 2:00 p.m. The CNA (#7) assisted Resident #1 to the toilet and laid her on the bed stating, "she needs to lay down so she's not leaning. She is tired." *06/18/24 in the TV room at 3:20 p.m., asleep and with her body and head tilted to the left. The CNA (#7) stated the resident was restless and wouldn't stay in bed so she got her up again. *06/19/24 in the TV room at 8:15 a.m. During an interview on 06/19/24 at 1:10 p.m., an administrative nurse (#2) stated the positioning device in Resident #1's care plan is for an "L-shaped pad" that is supposed to be on the resident's left side in the wheelchair. The administrative nurse agreed the positioning pad should have been in the resident's wheelchair. The facility failed to assess Resident #1's positioning needs. - Review of Resident #16's medical record occurred on all days of survey. A physician's order dated 05/14/24 stated, "Apply geri-sleeve [a compression device for edema/swelling and geri-sling [strapped sling] to left arm for swelling. Apply in the morning and remove at hs [hour of sleep] . . . for swelling to left arm". The care plan stated, ". . . Apply geri-sleeve and geri-sling to left arm for swelling. Apply in the morning and remove at hs . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition	F 684			

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F 684	Continued From page 16 eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, ". . . Carrying Out a Physician's Order . . . 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. Clarification from any other source is unacceptable and regarded as a departure from competent nursing practice". Observations of Resident #16 occurred on all days of survey and showed edema to the left hand and no geri-sleeve or geri-sling present. During an interview on 06/18/24 at 4:00 p.m., a nurse (#2) stated she assisted Resident #16 that morning and forgot to apply the geri-sleeve and sling. She also stated the sleeve and sling are "for swelling and he had quite a bit when they got the order." The facility failed to follow the physician's order to apply Resident' #16's geri-sleeve and sling daily.	F 684			
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	F 686		7/25/24	

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F 686	Continued From page 17 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide treatment and services to aid in the healing of pressure ulcers for 1 of 3 sampled residents (Resident #31) with current pressure ulcers. Failure to provide wound treatments as ordered may result in delayed healing or deterioration of a pressure ulcer. Findings include: Review of the facility policy titled "Physician/Practitioner Orders" occurred on 06/19/24. This policy, dated 04/01/24, stated, ". . . Wounds: Orders must be obtained for wound care including product to be used, when to change and when to reassess. . . . An order is required to discontinue a current order. . . ." Review of Resident #31's medical record occurred on all days of survey. Diagnoses included a healing stage IV pressure ulcer to the coccyx. Current physician's orders stated, "Cleanse wound with wound cleanser, pat dry, apply collagen powder to wound bed, lightly pack wound with calcium alginate, cover with 2x2 non bordered foam, and cover with a bordered 4x4 foam. Apply skin protectant to macerated wound edges and to surrounding skin every day shift for wound care." Observation on 06/18/24 at 2:38 p.m. showed a nurse (#10) donned gloves and a gown and	F 686	1) Resident #31 wound treatment order was updated on 06/26/24 and care is being provided as per order. Memo re-education provided by acting DNS to licensed nurses to provide pressure ulcer / wound treatment as per provider orders. 2) All residents with a wound or a pressure ulcer have the potential to be affected by the same deficient practice. 3) Re-education will be provided by GSS RN Regional Clinical Services Director to all licensed nurses on the importance of following orders as relates to residents' alteration in skin integrity, specific to wounds and pressure ulcers and providing care as per care plan to prevent and treat pressure ulcers. Education will be provided at the all staff meeting on July 25, 2024 or prior to next scheduled shift. 4) DNS or designee will conduct observation audits on three random residents with wounds to validate wound care is being provided as per order. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee for review and recommendations 5) The corrective action will be completed by July 25, 2024.		

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F 686	Continued From page 18 removed a dressing from Resident #31's coccyx. The nurse cleansed the wound with saline spray, applied collagen powder, and covered the wound with a 4 x4 bordered dressing. The nurse failed to apply calcium alginate, a 2 x2 nonbordered foam, and skin protectant.	F 686			
F 693 SS=D	During an interview on the afternoon of 06/19/24, an administrative nurse (#2) identified the wound was healing. Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 693			7/25/24
			1) Order received and followed to		

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F 693	Continued From page 19 facility policy, and staff interview, the facility failed to ensure appropriate gastrostomy tube (G-tube) care and services for 2 of 3 sampled residents (Resident #27 and #31) with a G-tube. Failure to communicate the dietician's recommendations related to tube feedings and label the tube feeding set with identifying information may result in undesired weight gain and complications related to tube feedings. Findings include: Review of the facility policy titled "Tube (Enteral) Feeding" occurred on 06/19/24. This policy, dated February 2024, stated, "... Tube (Enteral) Feeding Systems: ... Open Enteral system - An enteral system in which the person preparing the formula is required to decant formula into the entera container or bag. ... System Type - Open or gravity feeding: Change feeding administration set daily. Label the formula container, syringe and administration set with resident's name, date, time and nurse's initials. ..." - Review of Resident #27's medical record occurred on all days of survey. The current care plan showed, "... The resident requires tube feeding ... E/B [evidenced by] swallowing problem and order for NPO [nothing by mouth] status. ..." Resident #27's physician's orders identified, "Tube feeding Osmolite [nutritional supplement] 1.2 Cal [calories]: Give 1.5 [one and a half] bottles QID [four times a day]. Observation on 06/17/24 at 10:49 a.m. showed Resident #27 in bed with the head of the bed	F 693	discontinue resident # 31 tube feeding on 6/19/24. Memo re-education provided by acting DNS to licensed nurses to provide care as per provider orders, specific to tube feedings. 2) All residents with a feeding tube have the potential to be affected by the same deficient practice. 3) Re-education will be provided by GSS Regional Clinical Services Director to all licensed nurses on the importance of following orders as relates to tube feeding, as well as proper labeling of tube feeding. This education will be provided at an all staff meeting on July 25, 2024 or prior to next scheduled shift. 4) DNS or designee will conduct observation and documentation audits on three random residents with tube feedings to ensure tube feeding and flushes are being administered as per provider orders and the tube feedings are properly labeled. Audits will be completed 1 X / week for 4 weeks, then 1X/ month for 2 months. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee for review and recommendations 5) The corrective action will be completed by July 25, 2024.		

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F 693	Continued From page 20 elevated and an empty tube feeding bag connected to the resident with formula still visible in the tubing. The gravity feeding bag lacked a label to identify the type of formula, date, time, or initials. During an interview on 06/19/24 at 1:10 p.m., an administrative nurse (#2) stated her expectation is staff label all tube feeding bags with, at minimum, the date and time. - Review of Resident #31's medical record occurred on all days of survey. Diagnoses included gastrostomy tube, and dysphagia. Current physician's orders included "Peptamin [sic] [an enteral feeding solution] 1.5 continuous tube feeding at 60 ml/hr [milliliters per hour] from 2100-0500 [9:00 p.m. until 5:00 a.m.] . . . Monitor weights and notify provider if weight loss greater than 3 pounds. . . ." A dietician's note, dated 06/04/24 at 1:21 p.m., stated, ". . . Wt [weight]: 144# [pounds], up another 8# this month despite decrease in TF [tube feeding]. . . . Intake is 76-100% at meals. . . . Due to the continued weight gain, will D/C [discontinue] Peptamin [sic] feeding at night. Continue current water flushes. Expect weight to stabilize, but notify RD [registered dietician] if significant weight loss occurs. . . ." Observations on 06/18/24 and 06/19/24 showed G-tube feeding bags and a pump in Resident #31's room at 9:29 a.m. Staff members stated Resident #31 receives a tube feeding during the night but also eats meals by mouth. Review of Resident #31's medication	F 693			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - LAKOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 608 4TH AVE SW LAKOTA, ND 58344		
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F 693	Continued From page 21 administration record identified staff continued to administer Resident #31's tube feeding after the dietician's recommendation on 06/04/24.	F 693			
F 695 SS=D	During an interview on the afternoon of 06/19/24, an administrative nurse (#2) confirmed the facility failed to discontinue the feeding as recommended. 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 observation, record review, review of facility policy, and staff interview, the facility failed to provide respiratory care in accordance with professional standards and the resident's plan of care for 2 of 4 sampled residents (Resident #2 and #30) and one supplement resident (Resident #15) with oxygen therapy. Failure to follow physician's orders related to the flow of oxygen and change tubing regularly may result in complications related to oxygen use. Findings include: Review of the facility policy titled "Oxygen Administration, Safety, Mask Types" occurred on 06/19/24. This policy, dated 06/30/23, stated, ". .	F 695	1) Upon discovery on 6/19/24, Residents #2, #30, and #15 oxygen is administered as per provider order and oxygen tubing changed. Memo re-education provided by acting DNS to licensed nurses to administer oxygen as per provider order and to change oxygen tubing weekly. 2) All residents with oxygen orders have the potential to be affected by the same deficient practice. 3) Re-education will be provided by GSS RN Regional Clinical Services Director to all nursing staff on GSS Oxygen Administration Policy and Procedure, specific to following provider orders,		7/25/24

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F 695	Continued From page 22 . Oxygen administration is carried out only with a medical provider order. . . . Disposable equipment should be changed weekly or according to manufacturer's instructions and marked with date and initials. . . ." - Review of Resident #2's medical record occurred on all days of survey. Current physician's orders included, "Oxygen via nasal cannula 1 liter per minute [lpm] as needed for dyspnea [shortness of breath], hypoxia (O2 [oxygen] saturation less than 88%) or acute angina [chest pain]. Call provider/practitioner with nursing report as needed for dyspnea, hypoxia, acute angina," and "O2 NC [nasal cannula] keep Sats [oxygen saturations] above 90 [percent]." Observations on all days of survey showed Resident #2 continuously wore oxygen via nasal cannula at 2 lpm. Observations also showed Resident #2's portable oxygen tubing undated, and the tubing on the resident's room concentrator dated 05/16/24. The resident's medication administration record (MAR) lacked evidence of oxygen tubing changes. - Review of Resident #15's medical record occurred on all days of survey. Current physician's orders included, "Continuous oxygen therapy: 3L [liters]/NC at rest, 5L/NC with activity. . . ." Observations throughout the survey (both at rest and with activity [i.e., therapy]) showed Resident #15 wore oxygen via nasal cannula at 2 lpm. Observations showed undated tubing on both the portable and in room oxygen tubing. The resident's MAR lacked evidence of oxygen tubing	F 695	changing of oxygen tubing, and documentation. This education will be provided at an all staff meeting on July 25, 2024, or prior to the next scheduled shift. 4) DNS or designee will conduct observation audits on three random residents with oxygen to ensure oxygen is administered as per provider order with documentation and oxygen tubing change with documentation. Audits will be completed 1 X / week for 4 weeks, then 1X/ bi-weekly for 8 weeks, then 1 X / month for 3 months. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee for review and recommendations 5) The corrective action will be completed by July 25, 2024.		

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F 695	Continued From page 23 changes. - Review of Resident #30's medical record occurred on all days of survey. Current physician's orders included, "O2 orders.-- No oxygen at rest, 1Liter continuous with exertion at bedtime," and "Supplemental O2 at 2L. Pulmonology will reassess at next visit." Observations on 06/17/24 and the morning of 06/18/24 showed Resident #30 wore oxygen continuously via nasal cannula at 3 lpm. The resident stated lately she has needed more oxygen and has been wearing it at all times. Observations also showed the resident's oxygen tubing undated. The resident's MAR lacked evidence of oxygen tubing changes. During an interview on the afternoon of 06/19/24, an administrative nurse (#2) stated she would get the residents' oxygen orders clarified, and she expected staff to change oxygen tubing weekly.	F 695			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755			7/25/24

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F 755	Continued From page 24 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of narcotic record counts, and staff interview, the facility failed to recognize a tampered controlled medication container/packaging for 1 of 1 resident (Resident #27). Failure to physically examine the medication container/packaging for tampering in a timely manner increases the potential for medication error, loss, and diversion. Review of the facility policy titled "Medications: Controlled" occurred on 06/18/24. This policy, dated June 2023, stated, ". . . The on-coming nurse will physically examine the containers/packages of each controlled medication for evidence of tampering (open packages, taped packaging, medications that			F 755	1) The gabapentin taped into the hydrocodone cartridge was immediately destroyed on 6/18/24. Memo re-education by acting DNS to licensed nurses and medication aides on not borrowing medication and proper destruction of medication vs. returning them to cartridge. 2) All residents have the potential to be affected by the same deficient practice. 3) RE-education will be provided to all licensed nurses and medication aides by GSS RN Regional Clinical Services Director on GSS Medication Policies and Procedures specific to storage, administration, and destruction with proper documentation. Education will be		

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F 755	Continued From page 25 look different than others . . .)." Observations on 06/18/24 at 1:41 p.m. with a medication aide (#4) showed 16 tablets of Hydrocodone/acetaminophen, an opioid pain medication available for Resident #27. Closer examination showed one of the 16 tablets labeled G13, different than the others, and taped into the container. During this observation an administrative nurse (#2) identified the tablet as Gabapentin, a non-opioid pain medication and confirmed someone had tampered with the card.	F 755	provided on 7/25/2024 or prior to the next scheduled shift. 4) DNS or designee will conduct observation audits of controlled medications for integrity of cartridge and accuracy of sign out sheet. Audits will be conducted 1X / day for 5 days, then 1X / week for 3 weeks, then 1X / month for 2 months. DNS or designee observe medication administration pass for random sample of 3 nurses or medication aides utilizing the CMS-20056 Medication Administration Observation 1X / week for 4 weeks, then 1 X / month for 2 months. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee for review and recommendations 5) The corrective action will be completed by July 25, 2024.		
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, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 1 of 14 residents (Resident #136) and one supplemental resident (Resident #7) observed during medication administration. Two medication	F 759	1) Memo re-education provided to licensed nurse and medication aide by acting DNS on pre and post nebulizer treatment evaluation with documentation and not crushing extended-release medications. 2) All residents have the potential to be		7/25/24

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F 759	Continued From page 26 errors occurred during staff administration of 25 medications, resulting in an 8% error rate. Failure to properly administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of the facility policy titled "Medication: Documentation" occurred on 06/18/24. This policy, dated September 2023, stated, ". . . appropriate precautionary measures will accompany administration of certain medications and will be documented according to physician orders. . . ." Review of Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., New Jersey, page 65, stated, "Make sure the correct medications are given in the correct dose, by the right route, at the scheduled time, and to the right client." Review of Resident #136's medical record occurred on 06/17/24. A physician's order identified the medication Ipratropium-Albuterol Inhalation 1 application inhale orally every 4 hours . . . Document oxygen saturation, pulse, respirations, and lung sounds pre [before] & post [after] administration and record the total time (min.) [minutes] nursing spent with resident on treatment. - Observation on 06/17/24 at 3:31 p.m. showed a medication aide (MA) (#3) prepared and administered an Ipratropium-Albuterol Inhalation (nebulizer treatment) for Resident #136. A licensed nurse failed to complete a pre and post	F 759	affected by the same deficient practice. 3) Re-education will be provided to all licensed nurses and medication aides by GSS RN Regional Clinical Services Director on GSS Medication Administration Policy and Procedure specific to pre and post nebulizer treatment nurse evaluation with documentation and not crushing sustained- release medications. This will be presented at a nursing staff meeting on July 25, 2024, or prior to next scheduled shift. 4) DNS or designee will conduct observation and documentation audits on 3 random residents with nebulizer treatments to ensure pre and post nebulizer nurse assessments are completed and documented and observation audits of 3 random nurses or medication aides to ensure sustained release medications are not crushed. Audits will be completed 1 X / week for 4 weeks, then 1X/ bi-weekly for 8 weeks, then 1 X / month for 3 months. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee for review and recommendations 5) The corrective action will be completed by July 25, 2024.		

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F 759	Continued From page 27 assessment and failed to document vital signs and the total minutes spent with the resident. During an interview on the afternoon of 06/18/24, administrative nurse (#2) confirmed facility staff are expected to follow physician's orders as written. -Review of Mosby's 2023 Nursing Drug Reference "Administer Drugs Safely, Accurately, and Professionally," 36th ed., Elsevier, Inc., Missouri, page 1046, stated, ". . . Do not break, crush, or chew ext rel [extended release] tabs . . . dissolve effervescent [tablet designed to dissolve in water] tabs . . . in 8 oz cold water or juice . . ." Review of Resident #7's medical record occurred on 06/18/24. A physician's order identified a swallow evaluation completed. Medications included Potassium Chloride ER [extended release] daily. The medical record lacked instructions on how to administer this medication. - Observation on 06/18/24 at 8:14 a.m. showed a MA (#4) crushed and administered Potassium Chloride tablet in pudding to Resident #7. The MA (#4) failed to administer the medication dissolved in water/juice. During an interview on the afternoon of 06/18/24, an administrative staff member (#2) confirmed the MA administered the tablet incorrectly and confirmed the orders lacked details on how to administer the medication.	F 759			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812			7/25/24

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F 812	Continued From page 28 §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 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 facility policy, and staff interview, the facility failed to prepare, store, and serve food in a sanitary manner in 1 of 1 main kitchen and 1 of 1 resident nutrition center. Failure to label food with date/time, to discard expired food, clean soiled equipment, and use outdated test strips all have the potential to affect food quality/preparation, improper sanitation, and may result in the spread of foodborne illness to residents, staff, and visitors. Findings include: Review of the facility policy titled "Date Marking - Food and Nutrition" occurred on 06/18/24. This policy, dated April 2023, stated, ". . .	F 812	1) The food which was not date-marked in the nutrition fridge and kitchen refrigerator were discarded upon discovery on June 17, 2024. The discolored broccoli noted in the walk-in cooler was also discarded on June 17, 2024. The packages of meatball, sausage links and chicken breasts noted in the walk-in freezer were discarded on June 17, 2024. The ice chunk noted in the walk-in freezer was removed and the box which was affected had the contents removed and placed in a plastic container on June 17, 2024. The ice and water dispenser panel and drip/drainage pan was cleaned on June 17, 2024. The two		

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F 812	Continued From page 29 PROCEDURE . . . 2. When TCS [time, temperature control for safety] food has been opened but remains in storage, employees: a. Ensure ready-to-eat TCS foods opened at the locations are clearly date-marked for: 1. The date/time the original container is opened. 2. The date or day by which the food shall be consumed on the premises, sold, or discarded. . . . 4. A food item is discarded when: c. The container or package does not bear a date or day. d. The TCS item is beyond the use by date. . . ." Review of the facility policy titled "Safe Handling of Personal Food, Outside Food - Food and Nutrition" occurred on 06/18/24. This policy, dated May 2024, stated, "POLICY: Location ensures safe and sanitary storage, handling and consumption of foods brought to the resident by family or other visitors for personal consumption. . . . Personal food is stored separate from the location's food. . . . Employees remove foods deemed unsafe for consumption . . ." "PERSONAL FOOD STORED IN COMMON AREAS: ". . . Employees monitor common food storage areas . . . remove unsafe foods. . . ." *Observation of the main kitchen occurred on 06/17/24 at 10:30 a.m. with a nutrition services director (#11). Observations showed the following: Walk-in Cooler: - Individual servings of mandarin oranges (whole & puree) uncovered and undated sitting on a three-tiered cart. - One large container of blended shredded cheese not in the original container and lacked an open date/time.	F 812	sets of chemical test strips which were expired were removed on June 17, 2024 and replaced with strips that were not expired. The cheddar cheese dip which was in the nutrition fridge was removed on June 17, 2024. The open box of pizza rolls, ice cream, ice packs and mouth swabs were removed from the nutrition freezer on June 18, 2024. 2) All residents have the potential to be affected by this deficient practice. 3) Dietary and nursing staff will be re-educated by Director of Food and Nutrition on GSS Policy & Procedures: Date Marking, Food Supply & Storage, General Sanitation, and Ware washing, specific to proper food storage, date marking / destroying outdated and improperly stored items, separation of resident / staff food items, and storage separation of food and non-food items, cleanliness of ice / water machine and checking dates/ replacing expired chemical concentration test strips. Training will be completed at all staff meeting on July 25, 2024 or prior to their next scheduled shift. New practice established, cook or designee will check all refrigerators daily for date marked / outdated items and destroy any identified. Ice / water dispenser will be cleaned weekly. DFN will hold monthly dietary staff meetings to provide ongoing education of deficient practices identified. 4) Administrator or designee will conduct observation audits for proper food storage, date marking, ice water/dispenser cleanliness, expiration		

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F 812	Continued From page 30 - One gallon of lemon lime juice (half full) lacked an open date/time. - One gallon of fat free Italian dressing (half full) lacked an open date/time. - One large container of picante sauce (half full) lacked an open date/time - One container of discolored cut up broccoli covered in saran wrap dated 5/28/24. Walk-in Freezer: - Packages of meatballs and sausage links (in an unsealed bag), and not in original containers lacked the date/time the original packages were received and lacked an open date/time. - One large bag of breaded chicken breasts with visible ice crystals in an unsealed package in the original opened box. The chicken lack lacked an open date/time. - Observation showed a section of pipe covered with a large chunk of ice that dripped water onto an unopened box of food below it. The box showed water damage and had ice accumulated on top of it. Ice/Water Dispenser: - Ice and water dispenser panel and drip/drainage pan covered in of buildup of mineralization and debris. Chemical Test Strips: - Test strips used to test cleanser solution expired on 05/15/12. - Chlorine test strips used to test the chlorine level for the dishwasher expired on 03/01/24. *Observation of the resident nutrition center refrigerator/freezer occurred on 06/18/2024 at 3:50 p.m. and showed the following:	F 812	date of chemical strips stored by the quat sink and dishwasher, separation of resident and employee food, and separation of resident food and resident non-food items. Audits will be completed 1 X / day for 5 days, then 1 X / week for 3 weeks, then 1 X / month for 2 months. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee for review and recommendations. 5) The corrective action will be completed by July 25, 2024.		

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F 812	Continued From page 31 Resident Nutrition Center Refrigerator contained cheddar cheese dip lacked an open date/time. Resident Nutrition Center Freezer: - An open box of pizza rolls with original bag twisted closed. The box/bag lacked an open date/time. - Carmel delight ice cream (half full) lacked an open date/time. - Neapolitan ice cream (half full) lacked an open date/time. - Six ice packs. - Several packages of lemon mouth swabs. During an interview on 01/18/24 at 3:34 p.m., the nutrition services director (#11) confirmed the open food items lacked an open date/time and stated, "I expect staff to follow policy and procedures." During an interview on 01/18/24 at 4:00 p.m., an administrative staff member (#2) stated, "these [ice packs] should not be mixed with food."			F 812			
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			F 880			7/25/24

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F 880	Continued From page 32 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 §483.70(e) 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	F 880			

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F 880	Continued From page 33 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, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 2 of 3 sampled residents (Resident #27 and #31) observed with enhanced barrier precautions (EBP). Failure to practice infection control standards by ensuring staff use the proper personal protective equipment (PPE) has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Standard and Transmission-Based Precautions, All Service Lines" occurred on 06/19/24. This policy, revised 04/02/24, stated, ". . . Purpose . . . To prevent the spread of infection . . . Enhanced Barrier Precautions . . . Enhanced barrier precautions expand the use of PPE beyond situations in			F 880	1)Memo re-education provided by acting DNS to therapy and nursing staff on EBP proper gown and glove use. 2)All residents in enhanced barrier precautions have the potential to be affected by the same deficient practice. 3)RE-education will be provided to all facility and contracted staff by GSS RN Regional Clinical Services Director on enhanced barrier precaution, to include resident identification and PPE usage. This will be presented at an all staff meeting on July 25, 2024, or prior to next scheduled shift. 4) DNS or designee will conduct observation audits for three random residents on enhanced barrier precautions to ensure proper PPE is being utilized by staff. Audits will be completed 1 X / day for 5 days, then 1 X /		

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F 880	Continued From page 34 which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [multi drug resistant organisms] . . . Enhanced barrier precautions are needed for . . . Residents with Indwelling Medical devices (. . . indwelling urinary catheters . . . feeding tubes . . .) . . ." - Review of Resident #27's medical record occurred on all days of survey. Current physician's orders included tube feeding [four times a day]. Observation on 06/17/24 at 11:05 a.m. showed a sign on Resident #27's door stating, "Enhanced Barrier Precautions. A nurse (#9) without donning a gown or gloves, added water to Resident #27's tube feeding bag, flushed the line, and disconnected the tube feeding. The nurse failed to wear the appropriate PPE. During an interview on 06/19/24 at 1:10 p.m., an administrative nurse (#2) confirmed staff are to wear PPE for tube feedings. - Observation on 06/18/24 at 9:29 a.m. showed a sign on Resident #31's door identifying enhanced barrier precautions. A therapy staff member (#8) entered the room and without gowning or gloving, assisted Resident #31 to sit in an upright position and pivot to the edge of the bed for therapy exercises. During an interview on the afternoon of 06/19/24, an administrative nurse (#2) confirmed therapy staff should wear gowns and gloves while working in enhanced barrier precautions.	F 880	week for 3 weeks, then 1 X / month for 2 months. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee for review and recommendations 5) The corrective action will be completed by July 25, 2024.		

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F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of the North Dakota Plumbing Code, and staff interview, the facility failed to provide an air gap for 1 of 1 food-preparation sink (main kitchen) observed. Failure to provide the required air gap for a food-preparation sink has the potential to allow contamination of the sink in the event of sewer back up and bacterial migration. Findings include: Review of the 2018 North Dakota Plumbing Code, Section 801.2 Air Gap, or Air Break Required, stated, "Indirect waste piping shall discharge into the building drainage system through an air gap or air break as set forth in this code. Where a drainage air gap is required by this code, the minimum vertical distance as measured from the lowest point of the indirect waste pipe or the fixture outlet to the flood-level rim of the receptor shall be not less than 1 inch (25.4 mm)." Section 801.3.3 Food-Handling Fixtures, stated, "Food-preparation sinks, steam kettles, potato peelers, ice cream dipper wells, and similar equipment shall be indirectly connected to the drainage system by means of an air gap. Bins, sinks, and other equipment having drainage connections and used for the storage of unpackaged ice used for human ingestion or used in direct contact with	F 921	1) An air-gap was installed in the identified sink on June 26, 2024. 2) This deficient practice has the potential to affect all residents. 3) Education to all environmental services staff by administrator on the requirements of an air gap sink in food preparation areas by July 25, 2024. 4) Audits will not be necessary as the air-gap was installed in the sink identified to be compliant on June 26, 2024. 5) The corrective action has been completed on June 26, 2024.	6/26/24	

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F 921	Continued From page 36 ready-to-eat food, shall be indirectly connected to the drainage system by means of an air gap. Each indirect waste pipe from food-handling fixtures or equipment shall be separately piped to the indirect waste receptor and shall not combine with other indirect waste pipes. The piping from the equipment to the receptor shall be not less than the drain on the unit and in no case less than 1/2 of an inch (15 mm)." Observation on 06/17/24 at 10:30 a.m., showed a continuous drainage pipe passed into the wall with no visible air gap for the main kitchen food-preparation sink. During an interview on the afternoon of 06/17/24, an environmental services director (#12) lacked an air gap.	F 921			