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 _____	R-C 08/13/2024

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 An on-site revisit survey was conducted on 08/13/24 to determine compliance with deficiencies identified during the recertification survey completed on 06/19/24.	{F 000}		
{F 684} SS=D	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: Based on observation, record review, and staff interview, the facility failed to ensure staff provided care and services for 1 of 1 sampled resident (Resident #6) with an order for a geri-sleeve and geri-sling (prevents swelling and stabilizes the arm). Failure to apply the geri-sleeve and geri-sling as ordered or reevaluate the resident's need for the sleeve and sling may result in pain and increased swelling. Findings include: Review of Resident #6's medical record occurred on 08/13/24. A physician's order dated 05/14/24, stated, "Apply geri-sleeve and geri-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.	{F 684}	1) Upon discovery on 8/13/24, re-education was provided to all nursing staff on the importance of following Resident #6□s orders, specific to geri-sleeve and geri-sling. Later in the day of 8/13/24, Resident #6□s order for geri-sleeve and geri-sling was discontinued. 2) This deficient practice has the potential to affect all residents. 3) On 8/13/24, all staff were educated on accurate charting specific to if resident refuses or resists, chart REFUSAL and report to nurse. Do not document not applicable if resident refuses or resists care. 4) DNS or designee will perform observation and documentation audits on (3) three random residents to verify care	8/14/24

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

Electronically Signed | 09/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - LAKOTA	**608 4TH AVE SW LAKOTA, ND 58344**

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{F 684}	Continued From page 1 Apply in the morning and remove at hs . . ." Observations of on 08/13/24 from 10:30 a.m. to 4:45 p.m. showed Resident #6 without a geri-sleeve and geri-sling. present. During an interview on 08/13/24 at 3:37 p.m., two certified nurse aides (CNAs) (#1 and #2) stated Resident #6's geri-sleeve and geri-sling were discontinued. During an interview on 08/13/24 at 4:28 p.m., an administrative nurse (#4) confirmed Resident #6's orders for the geri-sleeve and geri-sling have not been discontinued and is still on the care plan.	{F 684}	is being provided as per orders/care plans with documentation. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2months. 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 has been completed as of August 14, 2024.	