STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355097	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LARIMORE	**501 E FRONT ST , LARIMORE, North Dakota, 58251**

(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
F0000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident (FRI) and a complaint was completed on July 9, 2025. During the FRI investigation, the facility was found non-compliant with regulatory requirements. During the complaint investigation the facility was found in compliance with regulatory requirements.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the facility reported incident (FRI), and review of facility policy, the facility failed to properly utilize assistive devices necessary to prevent accidents for 1 of 1 sampled resident (Resident #1) who fell during a staff assisted transfer. Failure to utilize the gait belt resulted in Resident #1's fall/fracture and placed all residents transferred with a gait belt at risk for injury. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings Include: The surveyor determined a deficient practice existed on 06/17/25. The facility implemented corrective action immediately and completed corrective action on 07/07/25.	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355097	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

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F0689 SS = G	Continued from page 1 Review of the facility policy titled “Gait Belt-Therapy & Rehab” occurred on 07/09/25. This policy, dated September 2024, stated, “Gait belts are used to aid patients during transfers and/or ambulation. The gait belt provides a firm grasping surface for the healthcare provider, protects the patient from accidental trauma, and helps reduce healthcare provider injury. . . .” Review of the initial FRI, dated 06/17/25, stated, “Resident had a fall at this time. CNA [certified nurse aide] [#1] called nurse on walkie to let this nurse know that resident had an assisted fall to the floor during transfer from wheelchair to recliner. Resident was being transferred with 1 staff assist and states that her knees gave out. . . . Resident assisted into recliner with hoyer [mechanical] lift and 2 staff assist. CNA reported that she observed resident hitting her head on dresser. . . .” Review of Resident #1's medical record occurred 07/09/25. Diagnoses included right hip fracture. The care plan stated, ". . . The resident has an ADL [activities of daily living] self-care performance deficit R/T [related to] weakness E/B [evidenced by] need for assist . . . TRANSFER: Resident requires assist of 1 . . .” Resident #1’s progress notes, dated 06/17/25, stated, at 8:21 p.m., ". . . Resident had a fall at this time. . . ." At 10:05 p.m. “. . . Resident sent to ER [emergency room] at this time for 10/10 [a numerical pain rating] pain in R) hip. . . ." The facility failed to ensure staff utilized a gait belt while assisting Resident #1. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented the following corrective actions to ensure all residents affected by the deficient practice were transferred in an appropriate manner: * Completed an investigation into Resident #1's fall/right hip fracture. * Educated CNA (#1) following the incident on 06/17/25 and 06/30/25. * Provided staff education regarding staff-assisted transfers/gait belt use via electronic messages and/or posted memos on 06/25/25 and 07/07/25.	F0689		