STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LARIMORE	**501 E FRONT ST LARIMORE, ND 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
F 000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident was completed on December 21, 2022. The concerns identified by the report were substantiated.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		1/18/23

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

Electronically Signed | 01/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LARIMORE	501 E FRONT ST LARIMORE, ND 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
F 609	Continued From page 1 Based on record review, review of State Survey Agency reports, review of facility policy, and staff interview, the facility failed to report timely to the State Survey Agency a potential incident of neglect for 1 of 1 sampled resident (Resident #1) who experienced a fall from a wheelchair during van transport. Failure to report all alleged incidents of neglect placed all residents at risk of neglect and subsequent injury. Findings include: Review of the facility policy titled "Abuse And Neglect" occurred on 12/21/22. This policy, revised 10/13/22, stated, ". . . Purpose . . . To ensure that all identified incidents of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported and investigated. . . . Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency. . . . If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source . . . and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made. . . ." Resident #1's progress notes identified the following: * 10/10/22 at 07:55 p.m., ". . . Resident was a near miss incident while out of facility returning from appointment. Driver called into the facility explaining that the resident slipped out of the chair because she put her arms up while in the van [the facility understood the resident slid under the shoulder harness] onto the footrest. The resident was pulled back into the seat 2	F 609	The alleged abuse incident for resident #1 was reported to North Dakota Department of Health on 11/23/22. This deficient practice has the potential to affect all residents. A review of all incidents since 10-10-2022 will be done by the Director of Nursing Services or Designee by 1-16-2023 to identify any additional incidents that should be reported to the North Dakota Department of Health. All staff was educated by Director of Nursing (DNS) on "Abuse and Neglect Rehab/Skilled" policy on 11-23-2022 and 11-25-2022. All staff will be re-educated by DNS or Administrator on Abuse and Neglect policy by 1-15-2023. All incident reports will be reviewed in morning stand-up with department managers to evaluate the need for incidents to be reported to North Dakota Department of Health. The Director of Nursing Services or Designee will monitor for compliance by auditing incidents to ensure policy for alleged Abuse/Neglect is followed for reporting violations. Audits will be completed on 3 incidents weekly x4, bi-weekly x4, monthly x3; results reported to quality committee until committee has determined continued compliance attained. Date of compliance is January 18, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LARIMORE	501 E FRONT ST LARIMORE, ND 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
F 609	Continued From page 2 person assist and returned to the facility. Resident denied pain and no injuries were noted. . . ." * 10/13/22 at 08:00 a.m., ". . . Resident is having increased pain to left knee. Call placed to physician for X-ray order. . . ." * 10/13/22 at 04:07 p.m., ". . . Per physician resident x-ray showed a fractured left femur. . . ." Review of the facility reported incident (FRI) identified Resident #1 slid out of her wheelchair during a van transport on 10/10/22 and was diagnosed with a fractured left femur on 10/13/22. The facility reported the fall to the State Survey Agency on 11/23/22 (44 days later). During interviews on 12/21/22 at 12:10 p.m., an administrative staff member (#1) stated the facility reported the incident on 11/23/22 as directed by the regional clinical coordinator. See F689	F 609		
F 689 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 facility policy, and staff interview, the facility failed to provide appropriate devices to secure a wheelchair and	F 689	Resident #1 - this was addressed on the date we re-enacted the transfer and determined incorrectly secured	1/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LARIMORE	501 E FRONT ST LARIMORE, ND 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
F 689	Continued From page 3 provide sufficient supervision to prevent accidents for 1 of 1 sampled resident (Resident #1) during a van transport. Failure to safely transport a wheelchair bound resident resulted in a fall and a fracture for Resident #1 and placed all residents requiring van transportation at risk for falls and injury. Findings include: Review of the facility policy titled "Abuse And Neglect" occurred on 12/21/22. This policy, revised 10/13/22, stated, ". . .Purpose . . . The location will have evidence that all alleged or suspected violations are thoroughly investigated. . . Procedure . . . 2. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause of injury. . . ." The facility failed to provide a policy/procedure for securing a wheelchair in a van. Review of Resident #1's medical record occurred on 12/21/22 and showed a diagnoses of displaced supracondylar (the thigh bone, or femur, is broken at the knee) fracture without intercondylar (extending into the knee) extension of lower end of left femur, subsequent encounter for closed fracture with routine healing. The current care plan stated, "The resident is at risk for falls R/T [related to] needs assist with all areas of mobility. . . . The resident has dementia E/B [evidenced by] significant memory loss and impaired judgement skills . . . Resident understands consistent, simple, direct sentences.	F 689	11-22-2022. This deficient practice has the potential to affect all residents transported via van that require transport in a wheelchair. The van drivers were educated with competency validation on proper technique/steps to secure residents with wheelchair mode of locomotion on 11-22-22, 11-29-2022, 12-12-2022 and on 1-6-2023. New seatbelts were ordered for the van from the manufacturer and installed. A process was put into place to ensure that a checklist is used with each transport of residents with wheelchair mode of locomotion. A process for tracking all resident transports was initiated on 1-4-2023, following gall staff education provided by Director of Nursing Service and Administrator that will be completed on 1-15-2023. A process for documenting transportation safety will be completed with each day of transport starting on 12-21-2023 with use of Transporting Residents in Wheelchairs Checklist. A transfer/transportation manual was placed in each vehicle with manufacturer's instructions on securing safety harness/belt, transporting checklist and other references to ensure a safe transport of residents in wheelchairs on 1-5-2023. Employee orientation of new staff who transport residents will be educated on the process and demonstrate competency of securing residents in wheelchair before	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LARIMORE	501 E FRONT ST LARIMORE, ND 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
F 689	Continued From page 4 . . ." The progress notes identified the following: * 10/10/22 at 07:55 p.m., ". . . Resident was a near miss incident while out of facility returning from appointment. Driver called into the facility explaining that the resident slipped out of the chair because she put her arms up while in the van [the facility understood the resident slid under the shoulder harness] onto the footrest. The resident was pulled back into the seat 2 person assist and returned to the facility. Resident denied pain and no injuries were noted. Son [name] and administrator made aware. Resident will be encouraged to keep arms down, dycem [an anti-slip pad] applied to seat and no blanket will be provided. . . ." * 10/13/22 at 08:00 a.m., ". . . Resident is having increased pain to left knee. Call placed to physician for X-ray order. Order received and resident will go to [name of community] lab via facility van driver for X-ray. POA [power of attorney] made aware. . . ." * 10/13/22 at 04:07 p.m., ". . . Per physician resident x-ray showed a fractured left femur. Family is aware . . ." The facility failed to provide van transportation logs that show departures, arrivals, and resident name when requested. The facility provided before and after a trip inspection reports for December 19, 20, and 21, 2022. No further inspection reports were provided. During an interview on 12/21/22 at 12:10 p.m., an administrative staff member (#1) stated the corporate office directed an investigation into the incident be performed. As part of the	F 689	first transport on their own. The Administrator or Director of Nursing Services will audit 4 transport of residents in wheelchairs to ensure process is followed weekly x4, bi-weekly x2, monthly x3 and report to Quality Committee until committee has determined sustained compliance has been achieved. Date of Compliance is January 18, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LARIMORE	**501 E FRONT ST LARIMORE, ND 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
F 689	Continued From page 5 investigation, the facility re-enacted the scenario on 11/22/22 and discovered the wheelchair harness should go over the shoulders of the resident and through the sides of the wheelchair, rather than around it and the van failed to have the appropriate harness. The facility immediately took the van out of use and ordered a new harness.	F 689		