

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

PRINTED: 07/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355106		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/06/2025	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER POINTE A PROSPERA CO				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 21ST ST SE MANDAN, ND 58554			
(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			F 000			
F 689 SS=J	An unannounced onsite investigation survey regarding a facility reported incident was completed on February 26-27, 2025. During the investigation the facility was found noncompliant with regulatory requirements. Based on the results of the investigation survey an extended survey was also completed on March 6, 2025. 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 observation, record review, review of the facility reported incident (FRI), review of facility training records, review of facility policy, review of manufacturer's guide, and staff interview, the facility failed to utilize devices necessary to prevent accidents and/or injury for 2 of 2 sampled residents (Resident #1 and #2) observed while in a spa chair. Failure to utilize the spa chair safety belt resulted in Resident #1 experiencing a fall and fracture and placed all residents at risk for falls and/or injury. During the on-site FRI investigation, the surveyor consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 02/23/25. The IJ resulted from the facility's failure to utilize the spa safety			F 689	F-689: Free of Accident Hazards/Supervision/Devices Bathing Care plan for Resident #1 was updated to Assist of two staff for whirlpool transfer into tub chair until belted in and then Assist of two staff out of the tub chair until into the wheelchair. Care plan review completed for resident #2 and it remains in place unchanged. All residents using the whirlpool tub have the potential to be affected by the identified practice. All Certified Nurses Aides that complete baths were retained using the Miller Pointe Bathing Aide CVTC (Competency verification and Training Checklist) All Certified Nurses Aides that complete		3/7/25

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

TITLE

(X6) DATE

Electronically Signed

03/21/2025

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 689	Continued From page 1 belt and the resident sustained a fracture. * 02/27/25 at 9:47 a.m. the surveyor notified the administrator and administrative nurses of the IJ situation, provided them with the IJ template, and requested a plan for removal of the IJ * 02/27/25 at 12:02 p.m., the surveyor and SSA reviewed and accepted the facility's removal plan. The removal plan contained the following: * Assessment and care plan changes for the residents observed, if needed. * Education for all the bath aides as well as skill validations will be completed on 02/27/25 * Plans for auditing the effectiveness of the training. * Reviewed and determination the current bathing policy will remain unchanged. * 02/27/25 at 3:04 p.m., the surveyor verified the implementation of the removal plan. The deficient practice remained at a scope and severity of a "G" following the removal of the IJ. Findings include: Review of the facility policy/procedure titled "Bathing" occurred on 02/26/25. This policy, dated 09/03/24, stated, ". . . The use of safety measures and equipment are designed to reduce the risk of injury to resident during a bathing experience. The manufacturer's directions for operating and maintaining equipment should be followed including the use of waist and chest safety belts/straps. . . ."	F 689	baths were checked off on the Safe Resident Handling Equipment competency validation checklist. All Certified Nurses Aides that complete baths watched the Penner cascade educational video. All Certified Nurses Aides that complete baths also reviewed and signed off on the Penner bathing Manual. Policy entitled SRHP-Safe Resident Handling Program Overview ☐ Rehab/Skilled, Long term care was reviewed and will remain in place unchanged. Miller Pointe Bathing Aide CVTC was reviewed and updated. QI Monitoring using the audit tool entitled Safe Resident Handling Equipment Competency Validation Checklist began the week of 2/28/25. Random audits of bathing will be completed weekly x 12 weeks, followed by monthly x 6 months. QI monitoring will be completed by the QI coordinator and/or her designee. QI monitoring will include resident #1 and #2. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and then summarized at the Quarterly QAPI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results.		

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F 689	Continued From page 2 Review of the "[manufacturer's name] Transfers and Stretcher Safe Operation [and] Maintenance Manual" occurred on 02/26/25. This guide, dated 10/16/20, pages 7-10, stated, ". . . 9. All residents must always be securely safety belted at the waist when using any of the . . . Lift Systems. . . . 22. Once the Transfer [spa lift chair] is clear of the spa, lower the Transfer to the lowest position . . . 24. Release the safety belts from around the resident and transfer the resident using proper nursing techniques and assistance as required." Review of the FRI, submitted to the SSA on 02/24/25, identified Resident#1 fell from the bath chair and sustained a nasal fracture on 02/23/25. - Review of Resident #1's medical record occurred February 26-27, 2025. The care plan identified the resident required assistance of one staff member for transfers using a mechanical stand lift, dressing, and bathing. Observation on 02/26/25 at 7:56 a.m. showed the certified nurse aide (CNA) (#4) completed Resident #1's bath. The CNA (#4) stood in front of the resident as she dressed him. Resident #1 sat in the spa lift chair without the safety belt in place and his feet approximately 12 inches off the floor. The CNA (#4) failed to follow facility policy and the manufacturer's guide related to safety belt use and the spa lift chair in the lowest position before dressing the resident. - Review of Resident #2's medical record occurred February 26-27, 2025. The care plan identified assistance of one staff for bathing. Observation on 02/26/25 at 8:34 a.m. showed the	F 689			

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F 689	Continued From page 3 CNA (#5) assisted Resident #2 on to the spa chair. The CNA (#5) failed to place the safety belt around the resident and raised the spa chair so Resident #2's feet were off the ground. During an interview on 02/26/25 at 12:25 p.m., administrative staff members (#1, #2, and #3) confirmed they expected staff to apply the safety belt and leave it in place while the residents are in the spa lift chair.			F 689			