STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355095	A. BUILDING _____ B. WING _____	C 01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OAKES	**213 N 9TH ST OAKES, ND 58474**

(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 complaint survey was completed on January 4, 2024. During the complaint investigation the facility was found noncompliant with regulatory requirements.	F 000		
F 689 SS=D	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 information provided by the complainant, record review, review of facility policy, and staff interview, the facility failed to ensure adequate supervision for 1 of 5 sampled residents (Resident #2) who experienced falls. Failure to provide supervision put the resident at risk of falls and/or injury. Findings include: Review of the facility policy titled "Fall Prevention and Management - Rehab/Skilled, Therapy & Rehab" occurred on 01/04/24. This policy, dated March 2023, stated, ". . . 3. Care plan the appropriate interventions, including personalizing all [sic] areas. 4. Communicate fall risks and interventions to prevent a fall before it occurs per the 24-Hour Report, care plan and Kardex, daily stand-up meeting, and/or Fall Committee meetings. . ."	F 689	For Resident #2 the Director of Nursing modified the charting to show hourly rounding is being documented by certified nursing assistants. Education was immediately provided to nursing staff on the importance of documentation to prevent injuries. This was completed on 01/04/2024. All residents who are identified for falls have the potential to be affected. Director of Nursing will monitor charting to assure documentation on falls is completed accurately at morning clinical review meetings. Director of Nursing will audit charting weekly for one month and will submit a report of findings to the next Quality Assurance committee meeting.	1/29/24

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

Electronically Signed | 01/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 1 The complainant identified concerns related to resident falls. Review of Resident #2's medical record occurred on 01/04/24. A care plan intervention, dated 09/20/23, stated, "Monitor resident every hour." Progress notes identified the resident fell on 10/11/23 and 10/25/23, and one resulted in a skin tear to the elbow. The facility failed to provide documentation to show hourly rounding occurred. On 01/04/24 at 12:45 p.m., an administrative staff member (#1) confirmed facility staff failed to ensure hourly rounding was being completed and documented.	F 689		