STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OAKES	**213 N 9TH ST , OAKES, North Dakota, 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
F0000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 01/05/26 and concluded on 01/07/26.	F0000		01/29/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels	F0584	Resident #4 fan was cleaned upon discovery on 1/8/2026. All residents have the potential to be affected by this deficient practice. Facility walk through conducted by maintenance on 1/8/2026 and all fans were cleaned. Administrator provided education to environmental service staff on Good Samaritan "Resident Environment" Policy and Procedure specific to clean environment on 1/8/2026. Fan cleaning was added to the environmental cleaning check off list. Maintenance supervisor or designee will audit fans to ensure they are clean 1 X per week X 4 weeks, 1 X per month X 2. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized for the quarterly QAPI meeting with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. This deficiency was corrected on 1/8/2026.	01/26/2026

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: 355095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/07/2026

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F0584 SS = D	Continued from page 1 in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide housekeeping services to maintain a safe, clean, comfortable and homelike environment for 1 of 3 sampled residents (Resident #4) on oxygen. Failure to clean personal fans does not provide a safe and clean environment and has the potential to place the residents at risk of illness. Findings include: Review of Resident #4's medical record occurred on all days of the survey. Diagnoses included chronic obstructive pulmonary disease with acute exacerbation, chronic bronchitis, emphysema, and chronic respiratory failure. Observations on 01/05/25 and 01/06/25 showed Resident #4 in bed with oxygen administered via nasal cannula and a fan blowing air directly at the resident. Observation showed the cover/grate and blades of the fan covered with dust.During an interview on 01/07/2026 at 1:00 p.m., an administrative nurse (#3) stated she expected staff to clean fans every three days.	F0584		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F0605	Resident #29 Hydroxyzine had a 14 day stop date on 1/8/2026. All residents on PRN psychotropic medications have the potential to be affected by this deficient practice. On 1/8/2026 all current residents with order for PRN psychotropic medications were reviewed for compliance with 14 day stop order requirements. All licensed nurses were educated by DNS or designee on 01/8/2026 on Good Samaritan Psychotropic Medication Policy and Procedure specific to PRN psychotropic stop order. IDT will review new PRN psychotropic medication orders during the morning clinical IDT meeting for inclusion of 14 day stop orders with immediate follow up if indicated. DNS or designee will audit PRN psychotropic medications for 14 day stop order 1X week X 4 weeks, 1X month X 2	01/26/2026

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F0605 SS = D	Continued from page 2 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F0605	Continued from page 2 months. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized for the quarterly QAPI meeting with the Medical Director in Attendance. The need for further monitoring will be determined based upon these results. This deficiency was corrected on 1/8/2026.	

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F0605 SS = D	Continued from page 3 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from unnecessary psychotropic medications for 1 of 2 sampled residents (Resident #29) who received an as needed (PRN) psychotropic. Failure	F0605		

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F0605 SS = D	Continued from page 4 to limit PRN psychotropic use to 14 days unless reevaluated by a practitioner placed the resident at risk of receiving unnecessary medications, experiencing adverse drug effects, and possible chemical restraint. Findings include: Review of the facility policy titled “Psychotropic Medications” occurred on 01/07/26. This policy, dated 12/09/25, stated, “. . . If the attending physician . . . believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician . . . evaluates the resident for the appropriateness of the medication. . . .” Review of Resident #29’s medical record occurred on all days of survey. Diagnoses included anxiety. A physician’s order, dated 12/08/25, identified Hydroxyzine (an antihistamine used for antianxiety) 25 mg (milligrams) every six hours PRN for generalized anxiety. The Medication Administration Record (MAR) showed Resident #29 received prn Hydroxyzine on nine occasions between December 23, 2025 and January 5, 2026. The facility failed to ensure the resident’s PRN Hydroxyzine was limited to 14 days and reevaluated for continued use. During an interview on 01/07/26 at 2:20 p.m., an administrative nurse (#3) confirmed facility staff failed to ensure the provider limited Resident #29’s PRN Hydroxyzine to 14 days and reevaluated for continued use.	F0605		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F0658	Upon discovery, nurse #4 was educated by DNS on proper technique of priming insulin pen. All residents receiving insulin pen administration have the potential to be affected by this deficient practice. All licensed nurses educated by DNS or designee on 1/8/2026 on Good Samaritan Medication: Insulin Administration Policy and Procedure specific to insulin pen priming. Illustrated instructions on insulin pen	01/26/2026

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F0658 SS = D	Continued from page 5 This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed standards of practice for 1 of 2 residents (Resident #40) observed for insulin preparation and administration. Failure to properly prepare and prime an insulin pen may result in contamination of the pen and administration of an inaccurate dose of insulin. Findings include: Review of the facility policy titled "Medicine: Insulin Administration, Insulin Pens, Insulin Pumps" occurred on 01/07/26. This policy, revised 10/31/25, stated, ". . . Insulin Pen. . . . 7. Wipe the tip of the pen where the needle will attach with an alcohol swab or cotton ball moistened with alcohol . . . 9. Turn the dosage knob to '2' units to prime the pen. 10. Holding the pen with the needle pointing upwards, press the button until at least a drop of insulin appears. . . ." Observation on 01/07/26 at 8:26 and 8:32 a.m. showed a nurse (#4) prepared Resident #40's Lantus and Novolog pens. The nurse applied a new needle to the insulin pens without wiping the tips of the pens with an alcohol swab, dialed the insulin pens to 2 units holding the pens horizontally, and with the needle covers on, primed the pens. During an interview on 01/07/26 at 1:30 p.m., an administrative nurse (#3) confirmed she expected staff to clean the insulin pen with alcohol prior to attaching needle and prime an insulin pen with the needle upright.	F0658	Continued from page 5 administration, including priming technique will be posted on each medication cart. DNS or designee will conduct observation audits of insulin pens to ensure proper technique of priming insulin pens 1 X week X 4 weeks, 1 X per month X 2. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized for the quarterly QAPI meeting with the medical director in attendance. The need for further monitoring will be determined based upon these results. This deficient practice was corrected on 1/8/2026.	
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent	F0686	Missed wound measurement documentation for Resident #2 was identified on 1/8/2026 and measurements were taken with documentation. Resident #2 wound dressing order changed on 2/4/2026 and was placed on the TAR for nurses to document. All residents with pressure ulcers have the potential to be affected by this deficient practice. All licensed nurses educated by DNS on Good Samaritan " Skin Assessment Pressure Ulcer Prevention and Documentation" policy specific to weekly wound measurements with documentation on the Wound Data Collection UDA and following wound orders and documenting on wound orders. IDT team will review wound documentation weekly during At Risk clinical meeting with measurements dates recorded. DNS or designee will conduct audit on all residents with wounds to ensure wound measurements have been	01/26/2026

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F0686 SS = D	Continued from page 6 infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide services to prevent skin breakdown and/or minimize the development of pressure ulcers for 1 of 3 sampled residents (Resident #2) with pressure ulcers. Failure to ensure the resident received treatments as ordered and reassess wounds in a timely manner may result in delayed healing of current pressure ulcers and/or the development of new pressure ulcers. Findings include: Review of the facility policy titled "Skin Assessment Pressure Ulcer Prevention and Documentation Requirements" occurred on 01/07/26. This policy, dated 12/08/25, stated, ". . . If a pressure ulcer is identified, cleanse the area prior to observations being made to allow the wound bed and depth to be more accurately observed. The registered nurse [RN] should record the type of wound and the degree of tissue damage on the Wound RN Assessment . . . The licensed nurse records the location of the area, the measurements, and the ulcer/wound characteristics. . . . Notify the physician . . . of the ulcer and resident's condition to obtain orders for a treatment. . . . The pressure ulcer should be assessed . . . at least weekly and documented on the Wound RN Assessment . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included an unstageable pressure ulcer to the right buttock. A "Response Request," dated 12/16/25, stated, ". . . This is to let you know that [Resident #2] has an are [sic] located on R [right] buttock . . . Size: Length 4.8 cm [centimeters], Width: 3.6 cm, Depth: 0 . . . Wound Bed: Granulation . . . Drainage Amount: Minimal . . . Additional Information . . . Random spots of excoriation within dimensions listed, mild sanguinous drainage, location at R buttocks, cleansed [with] wound cleanser and Mepilex applied. Further guidance? . . ." The physician's response, dated 12/17/25, stated, "Agree with above treatment - no new orders. . . ." The current physician's orders and treatment	F0686	Continued from page 6 completed and documented timely and wound orders are followed and documented on 1 X week X 4 weeks, 1 X per month X 2 months. Results of the QI monitoring will be reviewed as part of the monthly QAPI meeting with the medical director in attendance. The need for further monitoring will be determined based upon these results. This deficient practice was corrected on 1/8/2026.	

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F0686 SS = D	Continued from page 7 administration record (TAR) failed to address the use of the wound cleanser and/or Mepilex dressing. The "Wound Assessment" reports identified the following: * 12/26/25, ". . . right buttock pressure ulcer . . . open area and purple discoloration . . . 100% granulation . . . minimal drainage . . . denuded erythematous wound margins . . . no tunneling . . . clean with wound cleaner . . . apply Mepilex dressing . . ." * 01/02/25, ". . . right buttock excoriation . . . pressure ulcer . . . progressive healing of area . . . repositioning/turning . . . incontinence protection . . . friction/shear management . . . wound treatment . . . continue with current plan of treatment . . ." * 01/03/25, ". . . right buttock excoriation . . . no drainage . . . intact pink wound margins . . . no tunneling . . . Mepilex changed every 3 days . . ." During an interview on 01/06/26 at 9:40 a.m., when asked where staff document wound measurements, a nurse (#5) stated, "on the wound assessment" reports. The nurse confirmed Resident #2's record failed to show wound measurements. During an interview on 01/07/26 at 2:20 p.m., an administrative nurse (#3) confirmed facility staff failed to record wound measurements and failed to obtain an order for the wound cleanser and Mepilex dressing.	F0686		
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in	F0849	Resident #6 hospice election form was obtained from hospice on 1/7/2026 and scanned into OnBase. All hospice residents have the potential to be affected by this deficient practice. Facility leadership verified on 1/7/2026 that all current residents receiving hospice services have the required hospice election form uploaded in OnBase. Facility leadership received education on Documentation in the Clinical Record-Hospice Policy and Procedure by Regional Clinical Supervisor on 1/7/2026. IDT team will review hospice documentation verification in OnBase during clinical morning meeting. Administrator or designee will conduct audits on	01/26/2026

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F0849 SS = D	Continued from page 8 transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.	F0849	Continued from page 8 hospice residents that election forms are complete and scanned into OnBase 1 X per week X 4 weeks, 1 X per month X 2 months. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized for the quarterly QAPI meeting with the medical director in attendance. The need for further monitoring will be determined based upon these results. This deficient practice was corrected on 1/8/2026.	

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F0849 SS = D	Continued from page 9 (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is	F0849		

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(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
F0849 SS = D	Continued from page 10 responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the	F0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/07/2026

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GOOD SAMARITAN SOCIETY - OAKES	213 N 9TH ST , OAKES, North Dakota, 58474

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F0849 SS = D	Continued from page 11 services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the hospice agreement, and staff interview, the facility failed to ensure resident records contained the hospice election form for 1 of 2 sampled residents (Resident #6) receiving hospice services. Failure to obtain the hospice election form limits staff's ability to ensure coordination of care between the facility and the hospice agency. Findings include: Review of the facilities "Hospice and Nursing Facility Services Agreement," dated 04/17/20, stated, ". . . 3.1.16 Coordination of Services. Hospice shall: . . . (c) Provide Facility with the following information specific to each Hospice Patient residing at Facility . . . the hospice election form . . . " Review of Resident #6's medical record occurred on all days of survey and identified election of hospice services on 12/31/25. The medical record lacked the hospice election form. During an interview on 01/07/26 at 2:00 p.m., an administrative staff member (#3) confirmed Resident #6's medical record failed to include the hospice election form.	F0849		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	Moments of Hand Hygiene education provided to all staff by memo at time clock on 1/8/2026. All residents have the potential to be affected by this deficient practice. Infection Prevention designee educated facility staff on 1/8/2026 on Good Samaritan Hand Hygiene Policy and Procedure, specific to moments of hand hygiene. Hand Hygiene moments posted by residents bathroom glove dispensers. Infection Preventionist or designee will conduct observation audits on random Hand Hygiene opportunities weekly X4, then monthly X2 to ensure that proper infection control is maintained. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and then summarized at the	01/26/2026

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F0880 SS = D	Continued from page 12 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F0880	Continued from page 12 quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results. This deficient practice was corrected on 1/8/2026. Enhanced Barrier Precautions Enhanced Barrier Precaution PPE education provided to all staff by memo at the time clock on 1/8/2026 and each nurses station on 1/8/2026. Correct EBP signage and PPE for Residents #4, #6 and #7. All residents have the potential to be affected by this deficient practice. Infection Prevention Designee educated facility staff on 1/8/2026 on Good Samaritan Enhanced Barrier and Transmission based Precautions Policy and Procedure specific to PPE use for EBP. Infection Preventionist or designee will conduct random Enhanced Barrier Precaution audits specific to ensuring proper personal protective equipment is used weekly X 4, then monthly X 2. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and then summarized at the quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results. This deficient practice was corrected on 1/8/2026.	

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F0880 SS = D	Continued from page 13 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 14 sampled residents (Resident #4, #6, and #7) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions (EBP), donning/doffing of personal protective equipment (PPE), and hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Standard, Enhanced Barrier, and Transmission-Based Precautions" occurred on 01/07/26. This policy, revised 07/07/25, stated, ". . . Enhanced barrier precautions expand the use of personal protective equipment beyond situations . . . refer to the use of gowns and gloves during high-contact resident care activities . . . Enhanced barrier precautions are also used for residents with chronic wounds . . . even if the resident is not known to be infected with or colonized with an MDRO [Multidrug-Resistant Organism] . . . high-contact resident care activities include . . . changing briefs or assisting with toileting . . . and wound care . . . ." Review of the facility policy titled "Hand Hygiene" occurred on 01/07/26. This policy, revised 11/13/25, stated, ". . . All employees in patient care areas . . . will adhere to the 4 moments of Hand Hygiene . . . 1. Entering Room 2. Before Clean Task 3. After Bodily Fluid/Glove Removal 4. Exiting Room . . . Gloves are a protective barrier . . . 2. Hand hygiene should be performed after glove removal. . . . After removing gloves regardless of task completed . . . After contact with a patient's non-intact skin, wound dressings . . . when moving from contaminated body site to a clean body site during patient care . . ." - Review of Resident #4's medical record occurred on all days of survey. The current care plan stated, ". .	F0880		

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F0880 SS = D	Continued from page 14 . The resident requires Enhanced Barrier Precautions [EBP] chronic wound E/B [evidenced by] stage 2 pressure ulcer on coccyx . . ." Observation on 01/06/26 at 9:34 a.m. showed an EBP sign on Resident #4's door frame. A certified nurse aide (CNA) (#7) performed a brief change wearing gloves but failed to wear a gown. - Observation on 01/06/26 at 3:03 p.m., showed an enhanced barrier precaution sign and PPE container on Resident #6's door. Outside of the resident's room, a nurse (#2) and a CNA (#1) applied gowns and gloves. The staff members failed to perform hand hygiene prior to applying gowns and gloves and entering Resident #6's room. - Review of Resident #7's medical record occurred on all days of survey. The current care plan stated, ". . . The resident requires Enhanced Barrier Precautions [EBP] E/B indwelling catheter . . ." Observation on 01/07/26 at 8:45 a.m. showed an EBP sign on Resident #7's door frame. A staff nurse (#5) and CNA (#6) performed hand hygiene, donned PPE, and entered Resident #7's room. The nurse (#5) removed the soiled dressings from the buttock's wounds, removed the soiled gloves, and without performing hand hygiene, applied clean gloves to complete the dressing change. During an interview on the afternoon of 01/07/26, an administrative nurse (#3) confirmed she expected staff to wear personal protective equipment (PPE) while performing brief changes while on EBP precaution and to perform hand hygiene before applying gloves and after removing gloves.	F0880		