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 _____	10/03/2024

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 The Standard Medicare/Medicaid recertification survey was started on 09/30/24 and concluded on 10/03/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		11/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/31/2024

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and resident interview, the facility failed to provide care in a manner that maintained, enhanced, and respected the resident's dignity and individuality for 1 of 1 confidential resident (Resident B) who voiced concerns regarding nighttime toileting preferences.. Failure to honor the resident's choice for toileting does not enhance the resident's quality of life and may result in decreased self-esteem, decreased quality of life, emotional harm and increased pain. Findings include: Review of the facility policy titled "Resident Dignity" occurred on 10/03/24. This policy, dated November 2023, stated, ". . . PURPOSE . . . To assist with respecting and ensuring resident rights. . . . will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of her individuality. . . ." During a confidential resident interview on 10/01/24 at 2:50 p.m., Resident B stated, "I use the sit-to-stand lift during the day and evening, but I compromised with them to use the bedpan at night from 10:00 p.m. to 6:00 a.m. so they	F 550	1. There are two residents that meet the criteria for bedpan usage during the evening. Both residents were interviewed and no care plan changes were necessary for Residents A and B based upon both residents wishes for toileting preferences. 2. Two residents have the potential to be affected by this deficient practice. 3. All staff will be re-educated on GSS Resident Dignity policy and procedures specific to including residents individualized preferences in care plan and providing care as per care plan by DNS on 11/07/2024 or prior to next scheduled shift. 4. DNS or designee will audit 5 random residents documentation to ensure care is provided as per care plan and interview residents to ensure resident requests for toileting are being met. Audits will be completed 1X/week for 4 weeks, then 1X/month for 2 months. Any deficient practice will be addressed immediately. All audit findings will be submitted to	

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F 550	Continued From page 2 wouldn't have to have two CNAs [certified nurse aides] over on this side. I don't want to use the bedpan, I prefer to get up and use the toilet. I also have back problems, so sitting on the bedpan makes that pain worse." The facility failed to treat Resident B with dignity by honoring the resident's preferred method of toileting at night.	F 550	QAPI Committee for review and recommendation. 5. This deficiency will be corrected by 11/08/2024.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625		11/8/24

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F 625	Continued From page 3 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the resident or the resident's representative a written bed hold notice for 1 of 5 sampled residents (Resident #35) reviewed for hospital transfers. Failure to provide a written copy of the bed hold notice does not allow the resident and/or their representative to make an informed decision regarding their rights. Findings include: Review of the facility policy titled "Bed-Hold" occurred on 10/03/24. This policy, dated 12/07/23, stated, ". . . At the time of . . . transfer . . . , the location will provide written information to the resident or resident representative that specifies: 1. The duration of the state bed-hold policy, if any, during which a resident is permitted to return and resume residence. 2. The reserve bed payment policy in the state plan. 3. The location's policies regarding bed-hold periods permitting a resident to return. . . ." Review of Resident #35's medical record occurred on all days of survey and identified a hospital transfer occurred on 06/12/24. The medical record lacked documentation the facility provided the resident and/or representative with a written bed hold notice. During an interview on 10/02/24 at 2:03 p.m., an administrative staff member (#1) confirmed staff failed to provide the required bed hold notice to	F 625	1. Resident #35 was sent to the clinic for appointment and then was transferred to the hospital. Nurses were notified from the clinic of the transfer and called the daughter. Bed hold was verbalized but not signed or documented. Resident #35 bed hold was signed after re-admission on 06/20/2024. 2. All residents have the potential to be affected by this deficient practice. 3. Social Worker and nurses were re-educated on GSS Bed hold Policy and Procedure, specific to issuing bed hold to resident/responsible party at time of transfer, by Administrator and DNS on 11/07/2024 or prior to next scheduled shift. Facility will review all resident transfers at clinical meeting to ensure bed holds are being completed. 4. Administrator or designee will audit 100% of transfers for presence of complete bed hold and communication with resident/responsible party in a progress note. Audits will be completed 1X/week for 4 weeks, then 1X/week for 2 months. Any deficient practice identified will be addressed immediately. All audit findings will be submitted to QAPI Committee for review and recommendation.	

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F 625	Continued From page 4 the resident and/or their representative upon transfer to the hospital.	F 625	5. This deficiency will be corrected by 11/08/2024.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 3 sampled residents (Resident #26) who experienced a significant change in status. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status and identity and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.18.11), dated October 2023, page 2-24 stated, ". . . A 'significant change' is a	F 637	1. DON reviewed the MDS for Resident #26 and consulted with GSS Clinical Reimbursement Specialist and an annual MDS was completed on 09/03/2024 to show the significant change in status. 2. All residents have the potential to be affected by this deficient practice. 3. MDS Coordinator will be re-educated on GSS MDS 3.0 (Minimum Data Set) RAI policy and procedure, specific to Change in Condition MDS, by GSS Clinical Reimbursement Specialist by 11/07/2024. The clinical team will review residents during the weekly At Risk Meeting to identify residents meeting criteria for SCSA.	11/8/24

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F 637	Continued From page 5 major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-27 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . Any decline in an ADL [activities of daily functioning] physical functioning area (e.g., self-care or mobility) (at least 1) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individual's functioning. . . . " Review of Resident #26's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 06/05/24, identified the resident as independent with ambulation, personal hygiene, toilet transfer, sitting to lying position, lying to sitting position, sitting to standing, bed to chair transfer, moderate/partial assistance with lower body dressing and taking on/off socks and shoes and toileting hygiene, always continent of bowel and bladder, and did not use a wheelchair. The medical record identified the resident had a fall on 07/09/24 resulting in a right lower leg fracture and hospitalization from 07/09/24 to 07/12/24. A quarterly MDS, dated 07/18/24, identified the resident unable to ambulate, required a wheelchair for locomotion, frequently incontinent of bowel and bladder, dependent on staff for lower body dressing and taking on/off socks and shoes, required substantial/maximal assistance	F 637	4. DNS will audit residents medical record for resident change in condition meeting SCSA criteria, ensure completion of SCSA with supporting documentation. Audits will be completed 1X/month for 3 months. Any deficient practice identified will be addressed immediately. All audit findings will be submitted to QAPI Committee for review and recommendation. 5. This deficiency will be corrected by 11/08/2024.	

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F 637	Continued From page 6 with personal hygiene, and partial moderate assistance with toilet transfer, sitting to lying position, lying to sitting position, sitting to standing, and bed to chair transfer. The record lacked evidence facility staff identified and/or completed a SCSA following Resident #26's decline in activities of daily living.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 12 sampled residents (Resident #25, #32, and #40). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION GG: FUNCTIONAL ABILITIES AND GOALS The Long-Term Care Facility RAI Manual, revised October 2023, pages GG-14 through GG-16, stated, ". . . GG0130 Self-Care . . . Steps for Assessment 1. Assess the resident's self-care	F 641	1. Correction MDS was completed for Resident #25 related to GG0130 Self Care, for Resident #32 related to N0415 Medications, and for Resident #40 related to N0450 Medications and were submitted and submitted on 10/3/24. 2. All residents have the potential to be affected by this deficient practice. 3. MDS Coordinator will be re-educated on RAI requirements for accurate coding of section GG and section N by GSS Clinical Reimbursement Specialist on 11/07/2024. 4. DNS will audit sample of 5 MDS for accuracy of section GG and section N. Audits will be completed 1X/monthly for 3 months. Any deficient practice identified will be addressed immediately. All audit findings will be submitted to QAPI	11/8/24

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F 641	Continued From page 7 performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. . . . Coding instructions . . . Code 06, Independent: if the resident completes the activity by themselves with no assistance from a helper. Code 05, Setup or clean-up assistance: if the helper sets up or cleans up; resident completes activity. . . . Code 03, Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. . . ." Review of Resident #25's medical record occurred all days of survey. A Functional Abilities - Current Performance Assessment, dated 05/30/24, identified the resident required partial/moderate assistance for oral hygiene and walking 50 feet and 150 feet with two turns. The annual MDS, dated 06/01/24, identified the resident required setup or cleanup assistance for oral hygiene and independent with walking 50 feet and 150 feet with two turns. During an interview on 10/01/24 at 4:36 p.m., an administrative staff member (#1) confirmed staff failed to code the MDS correctly for Resident #25. SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2023, pages N-6 through N-7, stated, ". . . N0415: High-Risk Drug Classes: Use and Indication . . . Coding Instructions . . . N0415A1. Antipsychotic: Check if an	F 641	Committee for review and recommendation. 5. This deficiency will be corrected by 11/08/2024.	

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F 641	Continued From page 8	F 641		

antipsychotic medication was taken by the resident at any time during the 7-day look-back period . . . N0415B1. Antianxiety: Check if an anxiolytic medication was taken by the resident at any time during the 7-day look-back period . . . N0415G1. Diuretic: Check if a diuretic medication was taken by the resident at any time during the 7-day look-back period . . ." Pages N-12 through N-13, stated, ". . . N0450: Antipsychotic Medication Review . . . Coding Instructions for N0450A . . . Code 1, yes: if antipsychotics were received on a routine basis only . . ."

- Review of Resident #32's medical record occurred on all days of survey. The Admission/5 day (hospital return) MDS, dated 08/20/24, identified Section N0415 coded for an antianxiety medication. Review of the medication administration record (MAR) for August 2024 showed Resident #32 received Risperdal (an antipsychotic) during the look back period and lacked evidence the resident received an antianxiety medication.

During an interview on 10/04/24 at 4:40 p.m., an administrative staff member (#1) confirmed Resident #32 received an antipsychotic medication, not an antianxiety, and staff failed to code the MDS correctly.

- Review of Resident #40's medical record occurred on all days of survey. An admission MDS, dated 07/31/24, showed Section N coded for a diuretic medication. Review of the July 2024 MAR lacked evidence Resident #40 received a diuretic during the look back period.

During an interview on 10/03/24 at 10:30 a.m., an

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F 641	Continued From page 9 administrative staff member (#1) confirmed Resident #40 did not receive a diuretic and staff failed to code the MDS correctly.	F 641		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, confidential resident and family interviews, and staff interviews, the facility failed to provide sufficient nursing staff to	F 725	1. Resident council meeting was held on 10/23/2024 and residents were encouraged to express any	11/8/24

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F 725	Continued From page 10 meet the residents' needs for 4 of 4 confidential residents (Resident A, B, C, and D) and family members (Family member #1 and #2). Failure to provide sufficient nursing staff may result in residents experiencing falls, poor hygiene, incontinence, and skin issues and may negatively affect the residents' physical, mental, and psychosocial well-being. Findings include: - Review of Resident A's medical record occurred on 09/30/24 and identified the resident's most recent Brief Interview for Mental Status (BIMS) scored a 15, indicating intact cognition. The care plan stated, ". . . The resident has a need for restorative intervention due to Limited mobility . . . Resident will maintain current level of function . . ." Care plan interventions included use of an exercise bike, an arm machine, and static standing (seated wheelchair to standing). The care plan also identified the resident required bathing assistance. During an interview on 09/30/24 at 4:50 p.m., Resident A expressed concern with decrease in bathing from twice per week to once per week and stated, "We don't get restorative therapy anymore either, which I liked. I got it every other day. I need it for my leg. I really liked it. It really helped." When asked about these changes, Resident A stated, "I was told they don't have enough staff." - During an interview on 10/01/24 at 5:49 p.m., a confidential family member (#1) stated, "I wish they had more staff. Sometimes [Resident C] has to sit in his/her poop for a long time."	F 725	concerns/suggestion regarding decreased bathing and decreased restorative therapy in the gym. 2. All residents have the potential to be affected by this deficient practice. 3. Nursing staff was re-educated by DNS on developing residents care plan with residents choice and providing care as per care plan with documentation. Activities will be looking into larger group therapeutic activities to help with the decreased restorative gym time. Residents were made aware that if they would like the extra bathing to ask and DNS will look at schedule or staffing to meet the request. 4. DNS or designee will audit 5 random residents for documentation of bathing/restorative activity program participation as per care plan with resident interview for satisfaction in their bath schedule and restorative/activity program. Call light Audit for wait times will be completed 1X/month for 3 months. Any deficient practice identified will be addressed immediately and all audit findings will be submitted to QAPI Committee for review and recommendation. 5. This deficiency will be corrected by 11/08/2024.	

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F 725	Continued From page 11	F 725		

- Review of Resident D's medical record occurred on 10/02/24. The current care plan stated, ". . . The resident has a need for restorative intervention due to ADL [activities of daily living] self-care performance deficit/limited physical mobility activity intolerance . . . Resident will maintain current level of function in ADL's . . ." The care plan also identified the resident required bathing assistance.

During a confidential family interview on 10/02/24 at 3:18 p.m., Family member #2 expressed concern regarding the facility no longer providing the restorative therapy program for residents and decreased bathing for residents receiving two baths per week to one bath per week as Resident D previously received. When asked about these changes, the family member stated, "We were told these cuts were due to staffing, and we don't feel they should be taking things away from residents, especially baths and the restorative program. Isn't that the residents right to have therapy and two baths a week if they choose to?"

- Review of Resident B's medical record occurred on all days of survey and identified the resident's most recent BIMS scored a 15, indicating intact cognition. The care plan identified the resident required toileting assistance.

During an interview the afternoon of 10/01/24, Resident B stated, "They don't have enough staff. I've had to wait several times at least 30 to 45 minutes for someone to answer my light when I need to go to the bathroom. A couple weeks ago

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	355095	A. BUILDING _____ B. WING _____	10/03/2024

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

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F 725	Continued From page 12 I had to wet myself in the bed because I couldn't hold it any longer." During an interview on 10/03/24 at 9:51 a.m., an administrative staff member (#1) stated, "We decreased staff, decreased the number of baths per week, and discontinued the restorative therapy program around 09/19/24.	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or	F 732		11/8/24

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F 732	Continued From page 13 written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of the daily staffing information, review of the nurse schedule, and staff interview, the facility failed to post daily staffing data for all shifts on 9 of 11 days reviewed (September 22 - October 2, 2024). Failure to post accurate staffing data does not allow residents and visitors to be aware of the number of licensed and unlicensed staff on duty each shift. Findings include: Review of the daily staffing data and the nursing staff schedule from September 22 - October 2, 2024, showed on 11 of the days, staff failed to post the number of staff working on nine day shifts, two evening shifts, and five night shifts. During an interview on 10/03/24 at 10:59 a.m., an administrative staff member (#1) confirmed staff failed to post staffing data for each shift on some days.	F 732	1. Scheduler was unaware of the way the schedule was affecting the staffing numbers in the computer system. After review, the computer error was identified and resolved on 10/4/2024. 2. All residents have the potential to be affected by this deficient practice. 3. Scheduler and licensed nursing staff will be re-educated on GSS Nursing Staff Daily Posting Requirements policy and procedure by Administrator on 11/07/2024 or prior to next scheduled shift. 4. Administrator or designee will conduct observation audits for accurate required nursing staff posting 1X/week for 4 weeks, then 1X month for 2 months. Any deficient practice identified will be addressed immediately. All audit findings will be submitted to QAPI Committee for review and recommendation. 5. This deficiency will be corrected by 11/08/2024.	
F 791	Routine/Emergency Dental Srvcs in NFs	F 791		11/8/24

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F 791 SS=D	Continued From page 14 CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and	F 791		

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F 791	Continued From page 15 §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and resident interview, the facility failed to assist in obtaining dental services to meet the needs of 1 of 1 resident (Resident #3) with a lost bottom denture. Failure to promptly refer for dental services and/or assess the resident's ability to eat and drink adequately without a bottom denture may result in decreased intakes, unplanned weight loss, and choking. Findings include: Review of the facility policy titled "Denture and Oral Care, Dental Health Assessment, Dental Services" occurred on 10/03/24. This policy dated June 2024, stated, ". . . Referral for dental services for lost or damaged dentures must occur within three days of discovery of the lost or damaged denture. If the referral is more than three days, the location must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and document the extenuating circumstances that led to the delay. . ." Review of Resident #3's medical record occurred on all days of survey. A progress note, dated 09/06/24, stated. ". . . [Resident #3's name] states she is missing her her [sic] bottom	F 791	1. A care conference was held with resident #3 on 10/17/24 regarding missing dentures. The resident and family made the decision to not replace dentures at this time. 2. All residents have the potential to be affected by this deficient practice. 3. Social Services and Licensed Nurses re-educated by (who) on GSS Denture and Oral Care, Dental Health Assessment, Dental Services policy and procedure, specific to referral for dental services for lost or damaged dentures must occur within three days of discovery of the lost or damaged dentures on 11/07/2024 or prior to next scheduled shift. Social Service, Dietary and/or DNS will meet with resident with missing dentures to ensure nutritional/diet accommodations are made and to ensure a dental appointment is made within 3 days, with supporting documentation and care plan updates as indicated. 4. Director of Food and Nutrition or designee will audit medical record of 100% of residents who have lost dentures to ensure diet accommodations were made, dental appointment made / or	

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F 791	Continued From page 16 denture. She said she had them on Wednesday night but she couldn't find them on Thursday morning. She said she had staff look for them and they couldn't find them. She is going to call the dentist to see if there is a warranty . . ." During an interview on 10/02/24 at 1:35 p.m., Resident #3 stated, "I feel like they [Resident #3's lower denture] got thrown in the garbage by accident." When asked how the this affected her eating Resident #3 said she eats soft foods. The facility failed to refer Resident #3 for dental services within three days after being notified of the resident's missing lower denture and failed to complete an assessment of Resident #3's ability to eat and drink adequately.	F 791	declined with supporting documentation and care plan updates if indicated. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months. Any deficient practice identified will be addressed immediately. All audit findings will be submitted to QAPI Committee for review and recommendation. 5. This deficiency will be corrected by 11/08/2024.	
F 880 SS=E	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: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers,	F 880		11/8/24

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F 880	Continued From page 17 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.	F 880		

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F 880	Continued From page 18 §483.80(e) Linens. 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 practice for 4 of 12 sampled residents (Resident #17, #22, #32 and #39) and 5 supplemental residents (Resident #2, #6, #13, #21, and #31) observed during cares. Failure to follow infection control practices during resident cares related to hand hygiene, glove use, and enhanced barrier precautions (EBP) has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Standard and Transmission -Based Precautions" occurred on 10/03/24. This policy, dated April 2024, stated, "Enhanced barrier precautions expand the use of PPE [personal protective equipment] beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [multi-drug resistant organisms] to staff hands and clothing. . . . High-Contact Resident Care Activities include: Transfers . . . assisting with toileting . . ."	F 880	1. Upon discovery on 10/04/2024, DNS provided education to nursing staff on GSS Standard and Transmission Based Precautions specific to EBP and Hand Hygiene policy and procedures. 2. All residents have the potential to be affected by this deficient practice. 3. All staff will be re-educated by DNS on GSS Standard and Transmission Based Precautions and Hand Hygiene policies and procedures specific to PPE requirements for EBP and hand hygiene before donning gloves and between residents when passing fresh water prior by 11/07/2024 or prior to next schedule shift. 4. Director of Nursing or designee will conduce observation audits of 5 random staff members for proper use of PPE for EBP and for proper hand hygiene before/during/after resident care and during glove use. Audits will be completed 1X/week for 4 weeks, then 1X month for 2 months. Any deficient practice identified	

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F 880	Continued From page 19 Review of the facility policy titled "Hand Hygiene" occurred on 10/02/24. This policy, dated 03/29/22, stated, ". . . Definitions . . . Patient Zone . . . It contains the patient and their immediate surroundings. Typically includes intact skin of the patient and all inanimate surfaces that are touched by or in direct physical contact with the patient. . . . Policy . . . All employees in patient care areas . . . will adhere to the 4 moments of Hand Hygiene and 2 Zones of Hand Hygiene. 1. Entering Room 2. Before Clean Task 3. After Bodily Fluid/Glove Removal 4. Exiting Room 5. Zones: Patient zone . . ." ENHANCED BARRIER PRECAUTIONS: - Review of Resident #22's medical record occurred on all days of survey. The care plan stated, "The resident requires Enhanced Barrier Precautions (EBP) R/T [related to] surgical wound to left leg. . . ." A sign on the resident's door and a supply cart located in the room identified EBP for Resident #22. Observation on 09/30/24 at 12:48 p.m. showed a certified nurse aide (CNA) (#3) and a licensed nurse (#4) entered Resident #22's room with a stand lift, transferred the resident from the wheelchair to the toilet, provided toileting cares, and transferred the resident back to the wheelchair. The CNA and the nurse failed to wear a gown during the high-contact resident cares. Observation on 10/01/24 at 8:42 a.m. showed	F 880	will be addressed immediately. All audit findings will be submitted to QAPI Committee for review and recommendation. 5. This deficiency will be corrected by 11/08/2024.	

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F 880	Continued From page 20	F 880		

two CNAs (#2 and #3) entered Resident #22's room with a stand lift, transferred the resident from the wheelchair to the toilet, provided toileting cares, and transferred the resident back to the wheelchair. The CNAs failed to wear a gown during the high-contact resident cares.

- Review of Resident #32's medical record occurred on all days of survey. The care plan stated, " . . .The resident requires Enhanced Barrier Precautions (EBP) R/T open wounds d/t [due to] osteomyelitis [bone infection] on bilateral [both sides], multiple toes. . . ."

A sign on the resident's door and a supply cart located in the room identified EBP for Resident #32.

Observation on 10/01/24 at 5:49 p.m. showed a CNA (#2) entered Resident #39's room with a stand lift, transferred the resident from a wheelchair to the bathroom, provided toileting cares, and transferred the resident to a recliner. The CNA failed to wear a gown during the high-contact resident care.

During an interview on 10/03/24 at 11:14 a.m. an administrative staff member (#1) stated she expected staff to wear appropriate PPE during high contact cares for residents on EBP.

HAND HYGIENE:

- Observation on 10/01/24 at 12:48 p.m. showed two CNAs (#2 and #3) entered Resident #39's room, donned gloves without first completing hand hygiene, and provided the resident personal cares. Both CNAs acknowledged failure

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F 880	Continued From page 21 to complete hand hygiene upon entering the resident's room and donning gloves. - Observation on 10/01/24 at 1:11 p.m. showed a CNA (#2) provided fluids to Residents #2, #6, #13, #17, #21, and #31 by picking up a water mug located on the resident's bedside table in their room. The CNA (#2) failed to perform hand hygiene after assisting each resident with water and before assisting the next resident.	F 880		