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 10/15/2025

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 An unannounced onsite complaint survey was started on 10/07/25 and completed on 10/15/25. During the survey the facility was found noncompliant with regulatory requirements. Based on the results of the survey, an extended survey was conducted on 10/15/25.	F0000		11/04/2025
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, staff interview, and review of a Vulnerable Adult Protective Services (VAPS) report, the facility failed to ensure residents remained free from abuse for 2 of 2 sampled residents (Resident #1 and #2) who experienced nonconsensual sexual contact. Failure to protect residents from sexual abuse placed all residents at risk for psychosocial harm, physical harm, and mental and emotional distress. This citation is considered past non-compliance based on the review of the corrective actions the facility implemented immediately following the incident. During the on-site complaint survey, the team consulted with the State Survey Agency (SSA) and determined an	F0600	"Past Noncompliance - no plan of correction required"	11/04/2025

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 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

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F0600 SS = SQC-J	Continued from page 1 Immediate Jeopardy (IJ) situation existed on 10/04/25 when Resident #1 entered Resident #2's room, kissed the resident, and laid on his bed. Resident #2 was naked, straddled Resident #1, and put his hand inside her brief. *10/07/25 at 5:45 p.m. The survey team notified the administrator and director of nursing (DON) of the IJ, provided the IJ template, and requested a plan of removal for the IJ. *10/08/25 at 3:55 p.m. The SSA received the removal plan and accepted the plan. *10/09/25. The survey team confirmed by interview and record review the facility removed the IJ on 10/05/25 and corrected the deficient practice prior to the start of the survey on 10/07/25. The deficient practice is considered past noncompliance. The deficient practice remained a "G" scope and severity following the removal of the IJ. Findings include: Review of the facility policy titled "Abuse, Neglect and Exploitation Policy" occurred on 10/07/25. This policy, dated April 2025 stated, ". . . the resident has the right to be free from abuse, . . . residents must not be subjected to abuse . . . by other residents . . ." Review of the VAPS report, dated 10/04/25, stated a registered nurse (RN) entered Resident #2's room at approximately 8:00 p.m. and observed Resident #1 lying on the bed, and Resident #2 naked and straddling Resident #1 with his hands down Resident #1's pants. -Review of Resident #1's medical record occurred on 10/07/25. Diagnoses included Alzheimer's disease with psychotic disturbance. The admission Minimum Data Set (MDS), dated 05/04/25, identified severely impaired cognition. The care plan, at the time of the incident, identified a behavior of wandering in the halls. Resident #1's progress note, dated 10/04/25 at 11:00 p.m., stated, "At 2000 [8:00 p.m.], CNA [certified nurse aide] was looking for this resident [Resident #1]. This nurse told CNA to start looking in every room and this nurse would do the same. [Resident #1] often wanders into other rooms and sits there if they allow. . . . [Resident #1] was found in bed with her clothes on with his [Resident #2] hand rubbing her inside her pull up [brief] . . . This nurse waved for the CNA to	F0600		

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F0600 SS = SQC-J	Continued from page 2 come down the hall. CNA took [Resident #2's] hand out of [Resident #1's] pull up and walked with [Resident #1] to the recliner by the nurses station . . ." -Review of Resident #2's medical record occurred on 10/07/25. The admission MDS, dated 06/05/25, identified severely impaired cognition. The care plan, at the time of the incident identified the following: *Focus: Exhibits inappropriate touching. Intervention: Observe for interactions with female residents, specifically resident (identification number (ID)). *Focus: Displays inappropriate sexual behaviors such as exposing his genitals to staff, fondling himself in front of staff, and interlocked arms and touched the abdomen area of a female resident. Interventions: Observe interactions with female residents, specifically resident (ID number); separate residents if necessary; and provide resident with opportunities for socialization in supervised areas. A faxed request, dated 07/24/25, to Resident #2's provider stated, "Resident has been exposing genitalia to female staff, lying on bed fully undressed during night & day hours. Will cover himself when told to but exposes himself again. This started about 1 1/2 weeks ago. May we have a referral to psych [psychiatric] services?" The resident's provider responded the same day and stated, "referral to psychiatry. Dx: hypersexuality." Resident #2's medical record failed to show a psychiatry visit until 10/08/25, after the incident with Resident #1. Resident #2's progress note, dated 10/04/25 at 11:05 p.m., stated, "At 2000 [8:00 p.m.] . . .this resident and [Resident #1] was found in bed with her clothes on with this resident [Resident #2] hand rubbing her inside her pull up. [Resident #2] was completely naked laying [sic] next to her in bed . . . [Resident #2] explained she . . . kissed me 3 times . . . [Resident #2] has touched other residents in the past but they have not been in bed together . . ." The facility completed the following steps to remove the immediacy and correct the deficient practice: *Assessed Resident #1 and #2 for emotional and psychological distress. *Scheduled psychiatric appointments for Resident #1 and #2 for 10/08/25. *Initiated one to one (1:1) monitoring for Resident #1	F0600		

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F0600 SS = SQC-J	Continued from page 3 when wandering and to redirect and offer a movie or snack on 10/05/25. *Initiated 15-minute checks for both Resident #1 and #2 on 10/05/25. *Updated Resident #1's care plan to reflect 1:1 monitoring, 15-minute checks, and redirection on 10/06/25. *Updated Resident #2's care plan to reflect the incident and for staff to monitor the whereabouts of both residents. *Immediate education provided to all staff working on 10/04/25 and all other staff before the start of their next shift. *Education focused on how to identify/report resident-to-resident sexual abuse and the importance of implementing procedures to ensure resident safety. During an interview on 10/07/25 at 12:30 p.m., two administrative staff members (#1 and #2) stated Resident #1 can be flirtatious with staff and other residents and this was the first time staff witnessed the type of behavior between Resident #1 and Resident #2.	F0600		
F0609 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.	F0609	Upon discovery on 10/7/2025 DNS reported incident to ND SSA. On 10/7/2025, DNS and Administrator re-educated by Good Samaritan RCSD RN on ND Memorandum of Reporting with embedded link to report facility incidents, including potential sexual abuse to the SSA. All residents are at risk if the facility fails to report allegations of abuse or neglect. New facility process: Facility reportable added to morning meeting agenda and will be reviewed each business day by facility investigative team. Administrator and DNS will verify correct submission of initial report to DN SSA. Administrator or designee will audit resident incidents to verify if reportable submission to SSA was completed. Audits will be completed 1X week for 4 weeks, then 1X/monthly for 2 months, then 1X quarter for 3 quarters. All audits will be submitted to monthly QAPI Committee of review and recommendation.	11/07/2025

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F0609 SS = D	Continued from page 4 §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: Based on record review, review of facility policy, and staff interview, the facility failed to report an incident of resident-to-resident sexual abuse to the State Survey Agency (SSA) for 2 of 2 sampled residents (Resident #1 and #2) who experienced nonconsensual sexual contact. Failure to report incidents of abuse may result in unwanted physical and/or sexual contact, fear, anxiety, and psychosocial harm. Findings include: Review of the facility policy titled, "Abuse, Neglect and Exploitation Policy" occurred on 10/07/25. This policy, dated April 2025 stated, "Purpose: To ensure that employees are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations . . . Notification procedures: Alleged or suspected violations involving . . . abuse . . . will be reported immediately to . . . Designated agencies . . . including the State Survey and Certification Agency . . ." -Review of Resident #1's medical record occurred on 10/07/25. Diagnoses included Alzheimer's disease with psychotic disturbance. The admission Minimum Data Set (MDS), dated 05/04/25, identified severely impaired cognition. -Review of Resident #2's medical record occurred on 10/07/25. The admission MDS, dated 06/05/25, identified severely impaired cognition. Progress notes, dated 10/04/25, identified at 8:00 p.m. facility staff found Resident #1 in Resident #2's room fully clothed, and lying on the bed. Resident #2 was naked, straddling Resident #1, and had his hand in the resident's brief. During an interview on 10/07/25 at 9:58 a.m., two administrative staff members (#1 and #2) confirmed the facility failed to report the sexual interaction between Resident #1 and Resident #2 to the SSA.	F0609	Continued from page 4 Compliance date of 10/10/2025.	