STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355089	A. BUILDING _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PARK RIVER	301 SOUTH COUNTY ROAD 12B PARK RIVER, ND 58270

(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 started on 01/03/22 and concluded on 01/06/22.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		2/8/22

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

Electronically Signed | 01/28/2022

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 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, the facility failed to ensure the residents' rights to request, refuse, and/or discontinue treatment for 5 of 16 sampled residents (Resident #2, #10, #14, #27, and #195) reviewed for advance directives. Failure to discuss the residents' resuscitation status with the resident and/or the resident's representative and ensure the medical record accurately reflected each resident's code level limited the facility's ability to communicate to direct care staff and emergency personnel the residents' choice in the event of a medical emergency. Findings include: - Review of the medical records for Residents #2, #10, #14, and #195 occurred all days of survey. All records lacked documentation the facility staff discussed with the resident or resident representative, their choice to receive cardiopulmonary resuscitation (CPR) or do not resuscitate (DNR) and obtain signed documentation of their choice. During an interview on 01/05/22 at 2:31 p.m., a social services staff member (#7) reported the facility staff transferred/transcribed the residents'	F 578	1. Discussions held regarding resuscitation status with resident and/or the resident□s representative on the following dates: #2 January 26, 2022, #10 January 26, 2022, #14 January 26, 2022, #195 January 17, 2022 (with orders updated January 18. 2022) and #27 January 25, 2022 (with orders updated January 26, 2022). These directives have all been included in their respective records with a Health Care Provider signature. 2. All residents have the potential to be affected. 3. Education was provided by the Director of Nursing to the care plan team on January 24, 2022 regarding the policy on Advance Care Planning-Rehab/Skilled. 4. The Director of Nursing or designee will audit the records of new admissions and notes regarding care conferences weekly for two weeks, then monthly for three months, then as deemed necessary by the QAPI committee.	

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F 578	Continued From page 2 code status order from the transferring facility and agreed the facility staff failed to document the discussion of the code status choice with the residents and/or resident representatives. -Review of Resident #27's medical record occurred on all days of survey and identified the resident as cognitively intact. The resident's demograpic information stated, ". . . ADVANCE DIRECTIVE: Resuscitate (CPR) . . ." The resident's admission orders, dated 11/18/21, stated, ". . . DNR [Do Not Resuscitate] . . ." The medical record identified the following progress note: "12/07/21- Care conference note- Discussed advanced directives, resident wishes to be DNR, will work on getting the order changed. . . ." During an interview on 01/05/22 at 4:46 p.m., when asked about his wishes regarding CPR or DNR, Resident #27 stated, "I don't want any life saving measures."	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the	F 583		2/8/22

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F 583	Continued From page 3 residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to promote privacy and confidentiality of medication administration records (MAR) on 2 of 4 days (01/04/22 and 01/05/22) days of survey. Failure to close the MAR may result in unauthorized viewing of resident records by other residents, unlicensed staff and/or visitors. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 234, stated, ". . . ensure the privacy and confidentiality of client information stored in	F 583	1. Education provided to nurses to apply the screen saver when stepping away from the computer MAR (medication administration record) 2. All residents have the potential to be affected. 3. Education provided to nurses to assure privacy and confidentiality of the MAR on January 27, 2022. 4. The Director of Nursing or designee will audit the tablets being used for the MAR for confidentiality three times weekly for two weeks, then two times weekly for two weeks, then monthly for two months, then as deemed necessary by the QAPI committee.	

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F 583	Continued From page 4 computers. . . . Do not leave client information displayed on the monitor where others may see it. . . ." Observations showed the medication cart unattended with a resident's MAR visible on the computer screen during the following times: * 01/04/22 at 2:44 p.m. showed a licensed nurse (#6) leave the cart, returning after retrieving medications(approximately 12 minutes). * 01/05/22 at 4:08 p.m. showed a licensed nurse (#6) leave the cart and enter room 206 (approximately 5 minutes). * 01/05/22 at 4:30 p.m. showed a licensed nurse (#6) leave the cart and enter room 210 (approximately 7 minutes). During an interview on 01/06/22, an administrative nurse (#2) confirmed nursing staff should close the computer screen when the medication cart is left unattended.	F 583		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the	F 585		2/8/22

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F 585	Continued From page 5	F 585		

facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the

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F 585	Continued From page 6 identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	F 585		

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F 585	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, resident and staff interviews, and review of the Resident Council minutes, the facility failed to ensure prompt resolution of grievances from 8 of 11 confidential residents (Residents A, C, D, E, H, I, J, and K) attending the resident council interview. Failure to address the residents' concerns in a timely manner resulted in continued dissatisfaction regarding unsteady dining room tables and administering injections in the dining room. Findings include: Review of the facility policy titled "Resident Groups" occurred on 01/06/22. This policy, dated 09/28/21, stated, ". . . ensure that residents are provided a means of voicing grievances and participating in decision making . . . All grievances discussed at the group meeting will be written in meeting minutes and filed on the Suggestion or Concern form (#213). The procedure for handling the grievance will be followed. . . . Each department will respond to the resident group recommendations, concerns and grievances as requested and as appropriate, the plan of correction submitted to the administrator." Review of Resident Council meeting minutes from June - November 2021 occurred on 01/04/22. The meeting minutes identified the residents voiced the following concerns: * November, ". . . Tables 10 and 6 are wobbly. . . . Insulin shots are given in the dining room during meals. . . ."	F 585	1. All Residents were invited to Resident Council held on January 26th, 2022. Discussion of the concerns from the November 24, 2021 Resident Council Meeting were addressed by the Director of Nursing and the Maintenance Department. 2. All residents voicing a concern have the potential to be affected. 3. All concerns discussed at group meetings will be written on the Suggestion and Concern form #213 the day the concern is given and routed to the appropriate manager. 4. Administrator or designee will audit Resident Council Meeting Minutes for any concerns and if the Suggestion and Concern form #213 has been completed. Audit one time monthly for three months, one time monthly for one quarter. Then as QAPI committee deems necessary.	

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F 585	Continued From page 8	F 585		

The facility failed to provide December's Resident Council meeting minutes.

During the Resident Council interview on 01/04/22 at 2:30 p.m., the residents made the following statements regarding dining room tables and injection administration in the dining room during meals:

* Resident A and J stated, "Our [dining room] table is wobbly."
* Resident E and I stated, "Mine [dining room table] is like that too."
* Resident H stated, "My [dining room] table shakes, and it has been like that for months."
* Resident C, D, and K confirmed that some of the dining room tables are wobbly.
* Resident H stated, "I do not like them to give shots in the dining room, some residents do not like it. We have told them before, and they are still doing it."
* Resident J stated, "They give the shots right at the table, are they able to do that?"
* Resident A stated, "I think they should do that [shots] somewhere else."
* Resident C stated, "I get mine [insulin injection] in there [dining room]."
* Resident E stated, "I don't like them giving shots when I am eating, they just did it today."
* Resident D confirmed that some people don't want to see that [shots] in the dining room.

Observation on 01/04/21 at 4:24 p.m. showed the dining room tabletops (table #5, #6, #7, #9, and #10) loosely moved side to side when touched.

Observation on 01/05/21 at 12:11 p.m. showed a licensed nurse (#2) administered an insulin

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F 585	Continued From page 9 injection to Resident #34's abdomen while the resident sat at the dining room table. Residents seated on both sides and across from the resident witnessed the injection while eating their meal. Observation on 01/05/21 at 12:20 p.m. showed a licensed nurse (#2) administered an insulin injection to Resident #2's abdomen while standing at the medication cart parked near the dining room entrance. Multiple residents witnessed the injection as they entered the dining room. During an interview on 01/05/21 at 5:20 p.m., a social services staff member (#7) confirmed she failed to create a work order to fix the dining room tables following the November 2021 Resident Council meeting or complete the Suggestion or Concern form for the tables and insulin administration in the dining room during meals.	F 585		
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 observation, record review, review of facility policy, and staff interview, the facility failed to use an assistive device necessary to prevent	F 689	1. Resident #18 was referred to (PT) Physical Therapy. A PT evaluation was done on January 25, 2022. The care plan	2/8/22

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F 689	Continued From page 10 accidents for 1 of 4 sampled residents (Resident #18) observed during gait belt transfers. Failure to use a gait belt may result in falls and/or injuries. Findings include: Review of the facility policy titled "Gait-Transfer Belt" occurred on 01/06/22. This policy, revised April 2021, stated, ". . . PURPOSE To safely stabilize a transfer . . . 5. Do not use the pants/slacks belt as a gait (transfer) belt. . . ." - Review of Resident #18's medical record occurred on all days of survey. Diagnoses included dementia and osteoarthritis. The current care plan stated, ". . . The resident has an ADL (Activities of Daily Living) self care performance deficit R/T [related to] pain and weakness . . ." - Observation on 01/04/22 at 11:07 a.m., showed a certified nursing assistant (CNA) (#3) assisted Resident #18 from the bed to the wheelchair, guiding her to sit in the wheelchair by grasping the back of her pants. The CNA then pushed the resident's wheelchair into the bathroom up to the toilet and, without using a gait belt, assisted her to stand by grasping the back of her pants. The CNA pulled down the resident's pants and guided/pushed the resident's buttocks onto the toilet, stopping halfway through and rested the resident's buttocks on her leg. Upon completion of toileting, the CNA instructed the resident to stand and stated, "I'll help you," as she lifted under the resident's arm. The resident appeared unsteady and had to sit back down on the toilet three times while the CNA put a new product on the resident and pulled up her pants.	F 689	was updated to include use of a sit to stand lift for all transfers. 2. Any resident not using a mechanical lift has the potential to be affected, 3. Training and education was done by the Regional Clinical Leadership and Development Specialist on January 7 2022, January 11, 2022 and January 18, 2022. 4. The Restorative Nurse or designee will perform random audits of gait belt use during transfers one time weekly for four weeks, then monthly for three months, then as deemed necessary by the QAPI committee.	

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F 689	Continued From page 11 - Observation on 01/05/22 at 11:58 a.m. showed a certified nursing assistant (CNA) (#4) assisted Resident #18 from the bed to the wheelchair guiding her to sit in the wheelchair by grasping the back of her pants. The CNA then pushed the resident's wheelchair into the bathroom up to the toilet and, without using a gait belt, assisted her to stand by grasping the back of her pants. The CNA pulled down the resident's pants and guided/pushed the resident's buttocks onto the toilet. Upon completion of toileting, the CNA put a new product on the resident and pulled up her pants. The CNA then grasped the back of the resident's pants to turn her buttocks into the wheelchair and hit the resident's head on the wall. The resident loudly stated, "Ow." During an interview on 01/06/22 at 10:44 a.m., an administrative nurse (#2) agreed if staff assist Resident #18 with transfers they should be using a gait belt.	F 689		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		2/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355089	A. BUILDING _____ B. WING _____	01/06/2022

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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
F 812	Continued From page 12 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to store and label food appropriately in 1 of 1 kitchen (main kitchen). Failure to label food to identify the expiration date and discard expired food has the potential to result in foodborne illness to residents, staff, and visitors and decrease food quality. Failure to store food safely has the potential to cause cross-contamination. Findings include: Review of the facility's policy titled "Date Marking" occurred on 1/05/22. This policy, revised May 2021, stated, "To provide guidelines for proper date-marking to ensure that food is handled and stored safely . . . When TCS [time/temperature control for safety food] is received, employees . . . Observe for vendor's date of delivery and if not available, date-mark the item with the delivery date . . . Observe for USE by date or USE or Freeze by date. This is an expiration date . . . food items should remain in their original container/packaging . . . If the items are removed from the original container/package, individual items are labeled and dated with date of receiving . . . as much as possible, store food items in the original	F 812	1. On January 5, 2022 all outdated supplies and uncovered food was discarded. 2. All residents have the potential to be affected. 3. Education provided by Dietary Manager January 26, 2022 on Food Supply Storage and Date Marking. 4. Dietary Manager or designee will audit date-marking of food for when opened, use by date or when to be discarded, and all food is covered when opened or prepared. Audits will be three times weekly for one month, one time weekly for one month, then monthly for three months, then as deemed necessary by the QUPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355089	A. BUILDING _____ B. WING _____	01/06/2022

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F 812	Continued From page 13 container to retain manufacturer date guidance . . . A food item is discarded when . . . the container or package does not bear a date or day . . . The TCS item is beyond the USE by date . . ." The 2017 FDA (Food and Drug Administration) Food Code, Chapter 3.3 - Preventing Food and Ingredient Contamination, Section 3-302.11, stated, ". . . (A) FOOD shall be protected from cross contamination by . . . storing the FOOD in packages, covered container, or wrappings . . ." A dietary tour occurred on 1/03/22 at 1:18 p.m. Observation of food storage in the walk in freezer showed an angel food cake out of the original container/package and not labeled with the date prepared or a discard date, and three packages of biscuits in their original container/package, but not labeled with a discard date. Observation of food storage in the walk in refrigerator showed one container of grape juice out of the original container/package and not labeled or dated with a discard date. Observation of the dry food storage room in the main kitchen showed the following items beyond their use by/expiration dates: * One bottle of Karo syrup, use by date of 07/05/20 * Four boxes of instant oatmeal, use by date of 03/02/19 * Seven boxes of instant oatmeal, use by date of 11/13/19 * Four containers of instant coffee, use by date of 10/15/19 Observation of food storage in the walk in	F 812		

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 812	Continued From page 14 refrigerator and main refrigerator in the kitchen showed the following items uncovered/without lids: * Two bowls of blueberries with whipped cream * The spouts on two boxes of juice During an interview on 01/05/22 at 10:49 a.m., the dietary manager (#1) verified staff failed to label food items with a received and/or discard date, discard expired food, and cover food to prevent contamination. The facility failed to follow their policies related to date-marking for food safety/quality, discard food items by the use by date, and store food to prevent contamination.	F 812		