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 _____	C 02/19/2025

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 An unannounced onsite investigation survey regarding a complaint was completed on February 18-19th, 2025. During the complaint investigation the facility was found noncompliant with regulatory requirements.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to provide activities of daily living (ADLs) for 1 of 4 sampled residents (Resident #2) and 1 closed record (Resident #1) dependent on staff for personal hygiene and bed mobility. Failure to assist residents who cannot perform personal hygiene and bed mobility independently may result in poor hygiene, skin issues, and decreased self-esteem. Findings include: Review of the facility policy titled "Activities of Daily Living" occurred on 02/19/25. This policy, dated, December 2024, stated, ". . . Any resident who is unable to carry out activities of daily living (ADL's) will receive necessary services to maintain . . . grooming and personal hygiene . . . ADLs are those necessary tasks conducted in the normal course of a resident's daily life. Included in these are the following: 1. General Personal, Daily Hygiene/Grooming: Care of hair .	F 677	1. Resident #1 was no longer a resident at the time of the survey. Progress note for Resident #2 on 2-17-25 at 1530 stated that family had mailed clothes. Staff had given facility clothes to this resident but resident refused to wear them. Complete nail care was done on 3-10-25 as resident allowed. Resident also allowed professional hair care on that date. He has a diagnosis of anxiety and was unwilling to let staff care for him in the early days of his stay at the facility. Education was provided to morning and evening shifts on 3-10-25 regarding focus of his care. 2. All residents who are care planned for assistance with Activities of Daily Living (ADLs) have the potential to be affected. 3. Nursing staff will be re-educated on care for the dependent resident, including bed mobility, nail care, grooming and	3/24/25

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

Electronically Signed | 03/17/2025

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 _____	C 02/19/2025

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 677	Continued From page 1 . . nails . . ." - Review of Resident #1's medical record occurred on all days of survey and identified an admission date of 10/03/24. The resident expired on 10/05/24, approximately 48 hours after admission. The current care plan stated, ". . . The resident has an ADL self care performance deficit R/T [related to] weakness . . . Bed mobility . . . Assist of one . . ." Review of Resident #1's bed mobility/repositioning log, dated October 3 through October 5, 2024, identified the following: * 10/03/24 staff assisted with bed mobility at 2:34 p.m. and not again until 7:01 p.m. (4.5 hours later). * 10/03/24 staff assisted with bed mobility at 7:01 p.m. and not again until 12:57 a.m. (almost 6 hours later). 10/04/24 staff assisted with bed mobility at 9:25 a.m. and not again until 8:41 p.m. (11 hours later). - Review of Resident #2's medical record occurred on all days of survey. The current care plan stated, ". . . The resident has an ADL self care performance deficit . . . PERSONAL HYGIENE . . . Resident requires assist of one with personal hygiene. . . ." Observation on 02/18/25 at 4:26 p.m. showed Resident #2 in a wheelchair in the hallway with uncombed hair and long, dirty fingernails. Observation on 02/19/25 at 11:50 a.m. showed Resident #2 in the dining room wearing a shirt soiled with food and long, dirty fingernails.	F 677	cleanliness, and documentation of refusal of cares on 3-20-25. 4. Observation and documentation audits will be performed on 3 random dependent residents' cares (bed mobility and personal hygiene) as noted in the care plan by the Director of Nursing or designee 2 X a week for 2 weeks, then weekly for 2 weeks, then monthly for 2 months, then quarterly X 3 quarters. Any deficient practice identified with audits will be addressed immediately. All audit results will be submitted to the QAPI Committee for review and recommendation. 5. March 24, 2025	

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 _____	C 02/19/2025

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 677	Continued From page 2 The facility failed to assist dependent residents with personal hygiene and bed mobility.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		3/24/25

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 _____	C 02/19/2025

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 690	Continued From page 3 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, review of a professional reference, and staff interview, the facility failed to provide appropriate toileting for 2 of 4 sampled residents (Resident #4 and #5) and 1 closed record (Resident #1) who required staff assist with toileting. Failure to provide toileting may result in a loss of dignity and placed the residents at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and risk for fall and/or injuries. Findings include: Review of the facility policy titled "Activities of Daily Living" occurred on 02/19/25. This policy, dated December 2024, stated, ". . . Any resident who is unable to carry out activities of daily living [ADLs] will receive necessary services . . . ADLs are those necessary tasks conducted in the normal course of a resident's daily life. Included in these are the following . . .Toileting . . ." Kozier & Erb's "Fundamentals of Nursing: Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 892, stated, "Fecal and Urinary Incontinence: Moisture from incontinence promotes skin maceration [tissue softened by prolonged wetting or soaking] and makes the epidermis [skin] more easily eroded and susceptible to injury. Digestive enzymes in feces, urea in urine . . . also contribute to skin excoriation [area of loss of the superficial layers	F 690	1. Resident #1 was no longer a resident at this facility at the time of the survey. Resident #5 had no incontinent events and no negative impact as a result of the care provided on 2-18-25. Resident #4 was 15 minutes outside of her scheduled toileting plan. Staff had waited for surveyor as directed as she was on the phone. Education was provided to morning and evening nursing shifts on 3-10-25 regarding appropriate toileting, as well as proceeding with resident care even if surveyor not immediately available. 2. All residents with a toileting care plan have the potential to be affected. 3. Nursing staff will be re-educated on toileting care plans specific to offering and providing toileting per care plan and checking and changing of incontinence products per care plan on 3-20-25. 4. Observation and documentation audits on 3 random residents needing staff assistance with toileting to ensure care being provided as toileting is care planned will be done by the Director of Nursing or designee 2 X weekly for 2 weeks, then weekly for 2 weeks, then	

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 _____	C 02/19/2025

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 690	Continued From page 4 of the skin] . . . Any accumulation of secretions . . . is irritating to the skin, harbors microorganisms, and makes an individual prone to skin breakdown and infection. . . ." Page 1221 stated, "Managing Urinary Incontinence . . . Habit training, also referred to as timed or prompted voiding and scheduled toileting, attempts to keep clients dry by having them void at regular intervals, such as every 2 to 4 hours. The goal is to keep the client dry . . ." - Review of Resident #1's medical record occurred on all days of survey and identified an admission date of 10/03/24. The resident expired on 10/05/24, approximately 48 hours after admission. The current care plan stated, ". . . The resident has an ADL deficit r/t [related to] weakness . . . TOILET USE: . . . Resident requires a full lift and 2 assist with toileting . . ." Review of Resident #1's toileting log, dated October 3 through October 5, 2024, identified the following: * 10/03/24 staff assisted with toileting at 2:35 p.m. and not again until 8:38 p.m. (6 hours later). * 10/03/24 staff assisted with toileting at 8:38 p.m. and not again until 12:57 a.m. (4 hours later). 10/04/24 staff assisted with toileting at 9:25 a.m. and not again until 8:41 p.m. (11 hours later). - Review of Resident #4's medical record occurred on all days of survey. The current care plan stated, ". . . The resident has an ADL self care performance deficit . . . TOILET USE . . . Toilet per assist of one on arising . . ." Observation on 02/18/24 at 4:45 p.m. showed	F 690	monthly for 2 months, then quarterly X 3. Any deficient practice identified with audits will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendation. 5. March 24, 2025	

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 _____	C 02/19/2025

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 690	Continued From page 5 two certified nurse aides (CNAs) (#4 and #5) assisted Resident #4 to the bathroom. The resident's saturated incontinent product leaked urine through the resident's pants. The toileting log showed the resident last toileted at 1:48 p.m. - Review of Resident #5's medical record occurred on all days of survey. The current care plan stated, ". . . The resident has an ADL deficit . . . TOILET USE: . . . Resident uses assist of one and gaitbelt to toilet. Toileting schedule: Assist of one to toilet between 1530-1630 [3:30-4:30 p.m.] . . . and prn [as needed]. . . ." Observation on 02/18/24 at 3:50 p.m. showed two CNAs (#2 and #3) transferred Resident #5 from the recliner to the wheelchair and then to the commons area in the facility. The CNAs failed to offer toileting assistance to the resident. During an interview on 02/19/25 at 12:36 p.m., an administrative staff member (#1) stated she expected staff to assist residents with toileting per the care plan.	F 690		
F 880 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	F 880		3/24/25

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 _____	C 02/19/2025

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 880	Continued From page 6 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, 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	F 880		

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 _____	C 02/19/2025

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 880	Continued From page 7 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. 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 1 of 3 sampled residents (Resident #6) observed during cares. Failure to practice infection control standards related to hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 02/19/25. This policy, dated March 2022, stated, ". . . Policy: . . . All employees in patient cares areas . . . will adhere to . . . Hand Hygiene . . . 3 After bodily Fluid/Glove Removal . . . according to standard precautions . . . 2. Hand hygiene should be performed after glove removal . . . Procedure: HCW [Health Care Workers] will use waterless alcohol-based hand sanitizer or	F 880	1. Education was provided to nursing staff on 3-10-25 regarding staff removing gloves and performing hand hygiene after perineal cares. 2. All residents needing assistance with perineal cares have the potential to be affected. 3. Nursing staff will be re-educated on GSS hand hygiene policy and procedure, specific to glove use and hand hygiene before procedure, with glove change and removal with perineal cares on 3-20-25 by the Director of Nursing. 4. Observation audits of 2 random staff of hand hygiene/glove use during perineal cares will be performed by the Director of Nursing or designee 2 X weekly for 2	

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 _____	C 02/19/2025

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 880	Continued From page 8 soap and water to clean their hands: . . . After removing gloves regardless of task completed . . . After contact with a patient's excretions . . ." Review of Resident #6's medical record occurred on all days of survey. The Minimum Data Set (MDS), dated 12/6/24, identified dependent on staff for toilet hygiene. Observation on 02/18/25 at 4:04 p.m. showed two certified nurses aides (CNAs) (#2 and #3) donned gloves and transferred Resident #6 with the sit to stand lift from the wheelchair to the bed. The CNA (#3) cleaned the sit to stand lift with sanitizing wipes, checked and changed the resident's brief, obtained the tube of barrier cream left on the resident's bed, and placed it in the resident's top dresser drawer. The CNAs (#2 and #3) then transferred the resident back to the wheelchair using the sit to stand lift. The CNA (#3) cleaned the lift with the same gloves she donned at the start of the cares. CNA (#3) failed to change gloves and complete hand hygiene between tasks and after completing personal resident care. During an interview on 02/19/25 at 12:32 p.m., an administrative nurse (#1) confirmed she expected staff to remove gloves and perform hand hygiene after perineal cares.	F 880	weeks, then weekly for 2 weeks, then monthly for 2 months, then quarterly X 3. Any deficient practice identified with audits will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendation. 5. March 24, 2025	