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 06/08/2023

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

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey and a complaint survey started on 06/05/23 and concluded 06/08/23. The concerns identified by the complainant were not substantiated.	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	F 578		7/12/23

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

Electronically Signed | 07/06/2023

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F 578	Continued From page 1 has executed an advance directive, the facility may give advance directive information to the 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: THIS IS A REPEAT CITATION FROM THE STANDARD SURVEY CONDUCTED ON 01/06/22 Based on record review, review of facility policy, and staff interview, the facility failed to ensure the residents' rights to request, refuse, and/or discontinue treatment for 5 of 13 sampled residents (Resident #20, #27, #29, #31, and #240) 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 facility policy titled "Advance Care Planning" occurred on 06/07/23. This policy, revised 10/24/22, stated, ". . . Once the staff member has determined the wishes of the resident/healthcare decision-maker, the physician will be notified of the resident's wishes	F 578	1. Social service staff reviewed the individual Advance Directives with Residents #20, #27, #29, #31 and #240. Documentation of these discussions and any changes requested was noted under Progress Note Advance Care Planning. 2. All residents have the potential to be affected. 3. Re-education provided to the Administrator, Social Service staff and nurse managers by the Regional Clinical Service Director on July 06, 2023 regarding policies GSS Advance Care Planning and GSS Advance Directive including Cardiopulmonary Resuscitation and Automated External Defibrillator. These two GSS policies will also be added to the Resident Admission Packet. 4. Director of Nursing will complete audits of Advance Directive documentation weekly for 4 weeks, then monthly for 3 months, then as deemed necessary by the QAPI committee.	

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F 578	Continued From page 2 and asked to give orders. . . ." - Review of the medical records for Residents #20, #27, #29, #31, and #240 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 06/07/23 at 3:30 p.m., an administrative nurse (#2) and a social services staff member (#5) confirmed staff failed to discuss with the resident or resident representative their choice regarding CPR and/or DNR.	F 578	5. July 12, 2023	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 1. Based on observation, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 3 of 5 residents (Resident #2, #7 and #17) observed for insulin pen preparation. Failure to properly prepare insulin pens per policy may result in the resident receiving an inaccurate dose of insulin. Findings include: Review of the facility policy titled "Medication:	F 658	1. Education provided by Director of Nursing to nurses #6, #3, and #4 regarding priming of insulin pens on June 07 and 08, 2023. 2. All residents with orders for insulin have the potential to be affected. 3. Re-education provided by the Director of Nursing or designee to all licensed nurses on the policy Medication: Insulin	7/12/23

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F 658	Continued From page 3 Insulin Administration, Insulin Pens" occurred on 06/07/23. This policy, dated 04/26/23, stated, ". . . 9. Remove both the plastic outer cap and needle cap. 10. Turn the dosage knob to '2' units to prime pen. 11. Holding the pen with the needle pointing upwards, press the button until at least a drop of insulin appears. . . ." - Observation on 06/05/23 at 4:30 p.m. showed a nurse (#6) prepared two insulin pens to administer insulin to Resident #7. The nurse cleansed the tip of each pen with an alcohol swab, attached a needle and without removing the needle cap, primed both insulin pens at a horizontal angle. The nurse (#6) failed to remove the needle covers and hold the device upward to prime the pen. - Observation on 06/06/23 at 12:22 p.m. showed a nurse (#3) prepared an insulin pen to administer insulin to Resident #17. The nurse removed the outer and inner covers, held the pen horizontally and turned the dose knob to two units. The nurse (#3) failed to hold the device upward to prime the pen. - Observation on 06/07/23 at 8:25 a.m. showed a nurse (#4) prepared an insulin pen to administer insulin to Resident #2. The nurse removed the outer and inner covers, held the pen horizontally and turned the dose knob to two units. The nurse (#4) failed to hold the device upward to prime the pen. During an interview on 06/07/23 at 3:06 p.m., an administrative nurse (#2) stated she expects the nurses to prime the insulin pen with the needle pointed upward and not horizontal/sideways.	F 658	Administration, Insulin Pens by July 11, 2023 or prior to next scheduled shift. 4. The Director of Nursing or designee will complete audits of insulin administration twice weekly for 2 weeks, weekly for 2 weeks, then monthly for 2 months, then as deemed appropriate by the QAPI committee. 5. July 12, 2023 1. The nurse covered resident #22 left heel with the prescribed dressing on June 07, 2023. 2. All residents having wound dressing orders have the potential to be affected. 3. If a resident has an order for a dressing change that is not at least daily, a PRN dressing change will be scheduled in the Medication Administration Record to coincide with the bath day. Education provided by the Director of Nursing to all licensed nurses regarding the scheduling of dressing changes after bathing by July 11, 2023 or prior to the next scheduled shift. 4. The Director of Nursing or designee will complete audits of the presence of a new dressing after bathing weekly for 2 weeks, then monthly for 2 months, then as deemed necessary by the QAPI committee. 5. July 12, 2023	

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F 658	Continued From page 4 2. Based on observation, review of professional reference, record review, and staff interview, the facility failed to follow professional standards of practice for 1 of 4 sampled residents (Resident #22) with orders for wound dressings. Failure to follow physician's orders regarding dressing changes may result in delayed assessment, treatment, and worsening of the wound. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, states, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous not apparently erroneous, the nurse is responsible for carrying it out. . . ." - Review of Resident #22's medical record occurred on all days of survey. Current diagnoses included a pressure ulcer to the left heel. A physician's order, stated ". . . cleanse area . . . apply a foam dressing to left heel every 3rd day for altered skin integrity . . . after bath days . . . and as needed . . ." Observation on 06/07/23 at 3:59 p.m., showed Resident #22's left heel wound lacked a dressing. Review of Resident #22's treatment administration record (TAR) on 06/07/23 identified staff failed to complete the dressing change on the left heel pressure ulcer on 06/07/23 at 10:00 a.m. after the resident's bath.	F 658		

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F 658	Continued From page 5 During an interview on 06/07/23 at 4:10 p.m., a staff nurse (#3) stated she was not aware the resident had a bath today or the dressing was removed from the residents' left heel. The resident's left heel wound lacked a dressing from 10:00 a.m. to 4:25 p.m. (over 6 hours). During an interview on 06/07/23 at 4:30 p.m., an administrative nurse (#7) confirmed staff are expected to change dressings as ordered by the physician.	F 658		
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 interviews, the facility failed to ensure residents received adequate supervision/assistance to prevent accidents for 2 of 6 sampled residents (Resident #20 and #31) who required a mechanical lift for transfers. Failure to ensure proper use of a mechanical lift placed all residents at risk for accident and/or injury. Findings include: Review of the facility policy, "Mobility Support and Positioning" occurred on 06/07/23. This	F 689	1. Verbal education provided to nursing staff upon discovery of transfer concerns for Residents #20 and #31. On July 3, 2023, resident #31 received an order for Physical Therapy evaluation of transfer status. 2. Any resident using a mechanical lift has the potential to be affected. 3. Re-education provided by the Director of Nursing or designee for nursing staff by July 11, 2023 or next scheduled shift regarding safe transfers, including the use	7/12/23

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F 689	Continued From page 6 policy dated 03/29/23, stated, ". . . A calf strap is used when the resident requires additional lower extremity support or as a reminder not to step off the footplate while the sit-to-stand is in motion. If directed by the Kardex/kiosk/care plan or service plan fasten the shin straps to keep shins and feet in place. The shin/calf strap is used when the resident requires additional lower extremity support or a reminder to not step off the foot plate while the sit-to-stand is in motion. Apply the shin/calf strap when the resident is in a seated position, before rising to a standing position . . . alternate methods of leg strap placement may be necessary for some residents as instructed . . ." - Review of Resident #31's medical record occurred on all days of survey. The care plan stated, ". . . TRANSFER - Transfer Between Surfaces: with SS-M [Sit-to-stand, mechanical lift], leg strap, and staff assist of 1 . . ." Observation on 06/06/23 at 10:18 a.m. showed a certified nurse aide (CNA) (#1) applied a lift sling and transferred Resident #31 from the wheelchair to the toilet with the use of a sit-to-stand mechanical lift. The CNA (#1) failed to apply the resident's calf strap. Observation on 06/06/23 at 1:30 p.m. showed a CNA (#1) applied a lift sling and transferred Resident #31 from the wheelchair to the toilet with the use of a sit-to-stand mechanical lift. The CNA failed to apply the resident's calf strap. During an interview on 06/08/23 at 10:50 a.m., an administrative staff (#2) confirmed staff are expected to attach the calf strap when using a mechanical standing lift if the resident's care plan	F 689	of leg strap for those residents care planned for such and safe transfer when catheter tubing is present. 4. Restorative Nurse will perform random audits of mechanical lift transfers twice weekly for one week, one time weekly for 4 weeks, then monthly for 3 months, then as deemed necessary by the QAPI committee. 5. July 12, 2023	

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F 689	Continued From page 7 indicates it. - Review of Resident #20's medical record occurred on all days of survey. The care plan stated, ". . . resident has a foley catheter for bladder incontinence . . ." Observation on 06/06/23 at 10:31 a.m., showed a nurse (#7) and a CNA (#8) transfered Resident #20 from the bed to a wheelchair with the use of a full body mechanical lift. During the transfer, CNA (#8) applied a mesh lift sling in between the resident's legs. The tubing to the collection bag became tangled in the sling, pulling the tubing tightly, causing pain to the resident. This observer intervened and stopped the transfer. CNA (#7) unwrapped the tangled catheter tubing in the sling, and completed the transfer. During an interview on 06/07/23 at 4:30 p.m., an administrative nurse (#7) confirmed staff are expected to use caution to prevent injury when transferring residents with the mechanical lift.	F 689		