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 07/11/2024

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 and complaint survey started on 07/08/24 and concluded 07/11/24. During the complaint investigation, the facility was found noncompliant with regulatory requirements.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		8/9/24

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

Electronically Signed | 08/01/2024

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to follow physician's orders for 1 of 3 sampled residents (Resident #17) and 1 closed record (Resident #86) reviewed who experienced high and/or low blood sugars. Failure to notify the physician of blood sugar results above and/or below the ordered parameters may result in complications to the resident and prevent the physician from evaluating the need to alter treatment. Findings include: Review of the facility policy titled "Blood Glucose Monitoring, Disinfecting and Cleaning" occurred on 07/11/24. This policy, dated 01/31/24, stated, ". . . If the medical provider has identified a low and high blood sugar for a resident . . . when the	F 580	1. DNS verified that Resident #17 hi and low blood glucose parameters, as ordered, were in PCC vital sign module to alert nurse when entered blood glucose results are outside ordered parameters. On 7/18/24, re-education provided to licensed nurses by DNS that ordered parameters / thresholds are entered into PCC weight / vital sign monitor and notifying provider for blood glucose outside ordered parameters. Resident # 86 has discharged, therefore no correction was able to be completed. 2. All residents with a diagnosis of Diabetes Mellitus and requiring blood sugar monitoring have the potential to be affected. 3. Licensed nurses will receive	

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F 580	Continued From page 2 blood sugar varies from the baseline entered. . . . the nurse will notify physician if necessary, per parameters. . . ." - Review of Resident #17's medical record occurred on all days of survey. Diagnoses included type two diabetes mellitus. Medications included, "Insulin Aspart Injection Solution 100 UNIT/ML [milliliter] . . . related to TYPE 2 DIABETES MELLITUS WITH UNSPECIFIED COMPLICATIONS . . . For BS [blood sugar] > [greater than] 451 call MD [medical doctor]." Review of the January-July 2024 blood sugars log showed the following: * 01/03/24 - 453 mg/dL (milligrams per deciliter) * 01/07/24 - 458 mg/dL Review of the medical record showed the facility failed to notify Resident #17's physician of the blood sugar readings greater than 451. - Review of Resident #86's medical record occurred on all days of survey. Diagnoses included type two diabetes mellitus with hypoglycemia (low blood sugars) and insulin use. Medications included 10 milligrams (mg) Glipizide extended release one time a day, 20 units Humalog (short-acting insulin) two times a day (start date 03/29/24), 25 units Humalog one time a day (start date 03/30/24), 80 units Lantus (long-acting insulin) one time a day, and 500 mg Metformin HCl (Hydrochloride) (oral medication used to control high blood sugar) twice a day. The physician's orders included, "Call MD when blood sugars < (lesser than) 70 mg/dL or > 400 mg/dL."	F 580	additional re-education by DNS or designee on GSS "Blood Glucose Monitoring, Disinfecting & Cleaning" policy and procedure, specific to ordered parameters / entry into PCC and GSS "Notification of Change" policy and procedure, specific to notifying provider with resident change of condition and when blood glucose results are outside ordered parameters by 8/9/24 or prior to next scheduled shift. 4. DNS or designee will audit medical record documentation for residents with blood glucose monitoring with parameter orders to verify provider was notified of results outside ordered parameters. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months. Any deficient practice will be addressed immediately. Audit results will be submitted to QAPI Committee for review and recommendation. . 5. 8-09-2024	

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F 580	Continued From page 3 Review of the December 2023 blood sugars log identified a reading of 67 mg/dL on 12/27/23. The progress notes identified, * 04/24/24, ". . . Residents blood sugar was 62 [mg/dL] this morning. . . ." * 04/26/24, ". . . Residents blood sugar was 65 [mg/dL] this morning. . . ." A progress note, dated 04/27/24, further identified the facility transferred Resident #86 to the emergency room after she received Glucagon (medication used to treat low blood sugar) for a blood sugar reading of 42 mg/dL. Review of the medical record showed staff failed to notify Resident #86's physician of the low blood sugar readings on 12/27/23, 04/24/24, and 04/26/24.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		8/9/24

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F 582	Continued From page 4 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review, review of Medicare Part A letters/notices, and staff interview, the facility	F 582	1. The SNFABN for Resident #16 was issued via e-mail on 4-01-2024. The	

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F 582	Continued From page 5 failed to ensure the resident and/or their representative completed the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) for 1 of 3 supplemental residents (Resident #16) discharged from Medicare Part A in the past six months. Failure to ensure the completion of the SNFABN limited the resident/representative's ability to exercise their rights regarding Medicare Part A services. Findings include: Review of Medicare Part A beneficiary notices identified Resident #16 discharged from Medicare Part A on 04/03/24. The SNFABN failed to identify if the resident and/or her representative chose to continue or discontinue services or request a demand bill. Review of Resident #16's medical record occurred on 07/11/24. The record lacked documentation the resident and/or representative was informed of options related to billing and services when Medicare Part A coverage ended. During an interview on the morning of 07/11/24, an administrative staff member (#1) confirmed staff failed to document whether staff informed Resident #16 and/or her representative of their options related to billing and services when Medicare Part A coverage ended.	F 582	document was received on 7-08-2024 with documentation of the representative's chosen option. 2. All residents on Medicare services have the potential to be affected. 3. Re-education provided to facility Medicare clinical team by GSS Compliance Analyst on GSS "Notice of Medicare Non-Coverage (NOMNC)", GSS "SNF Medicare Part A Advance Beneficiary Notice of Non-Coverage (SNFABN)", and GSS SNF Medicare Team Meetings policy and procedures specific to notification requirements on 8/9/24. 4. Business Office Manager or designee will audit completion of SNFABN and NOMNC forms on 100% of residents meeting the criteria for issuance / notification. Audits will be completed 1 X / month for 2 months. Any deficient practice identified will be addressed immediately. Audit results will be submitted to QAPI Committee for review and recommendations. 5. 8-09-2024	
F 641 SS=E	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	F 641		8/9/24

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F 641	Continued From page 6 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 5 of 12 sampled residents (#1, #3, #13, #15, and #25). 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, GG-15, and GG-21, states ". . . Individualized care plans should be based on an accurate assessment of the resident's self-performance and the amount and type of support being provided to the resident. . . . Steps for Assessment 1. Assess the resident's self-care 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. CMS [Centers for Medicare & Medicaid Services] anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period. . . . A dash ("-") indicates 'No information.' CMS expects dash use to be a rare occurrence."	F 641	Modification of the MDS dated 4-05-2024 for Resident #1 was completed on 7-30-24 to include the use of a feeding tube and a mechanically altered diet. No modifications were able to be done for Residents #3, #13, #15, #25. 2. All residents have the potential to be affected. 3. Education was provided on 7-30-2024 to nurse managers, Certified Dietary Manager, Director of Nursing and Administrator by the Good Samaritan Senior Clinical Reimbursement Analyst regarding accurate completion of the MDS. System change: the Functional Abilities UDA (User Defined Assessment) when the MDS is opened. 4. DNS or designee will audit Section GG and K0520 of the MDS for accuracy and for dashing of questions on 100% of MDS completed 1 X / week for 4 weeks, then 1 X / month for 2 months. Any deficient practice identified will be addressed immediately. 5. 8-09-2024	

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F 641	Continued From page 7	F 641		

- Review of Resident #3's medical record occurred all days of survey and included diagnoses of hemiplegia (partial or total paralysis on one side of the body) and hemiparesis (one-sided muscle weakness caused by brain, spinal cord, or nerve problems) following cerebral infarction (stroke) affecting left dominant side.

Resident #3's quarterly MDS, dated 05/20/24, showed Section GG with dashes in the areas of oral hygiene, upper and lower body dressing, putting on footwear, and transfers. The MDS failed to identify the resident's ability or assistance required in these areas.

- Review of Resident #13's medical record occurred all days of survey. The record identified diagnoses of Parkinson's disease (progressive disorder that affects the nervous system and causes tremors, stiffness, and slow movement) with dyskinesia (uncontrolled, involuntary movements of the face, arms or legs) and dementia.

Resident #13's quarterly MDS, dated 04/24/24, showed Section GG with dashes in the areas of oral hygiene, toileting hygiene, showering/bathing, upper body dressing, lower body dressing, and putting on/taking off footwear. The MDS failed to identify the resident's ability or assistance required in these areas.

- Review of Resident #15's medical record occurred on all days of survey and included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.

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F 641	Continued From page 8 Resident #15's annual MDS, dated 04/22/24, showed Section GG with dashes in the areas of oral hygiene, toileting, upper and lower body dressing, putting on footwear, personal hygiene, and transfers. The MDS failed to identify the resident's ability or assistance required in these areas. - Review of Resident #25's medical record occurred on all days of survey and included diagnoses of pain in left shoulder, polyneuropathy (damage to multiple peripheral nerves), and abnormalities of gait and mobility. Resident #25's quarterly MDS, dated 04/26/24, showed Section GG with dashes in the areas of oral hygiene, bathing, upper and lower body dressing, putting on footwear, and transfers. The MDS failed to identify the resident's ability or assistance required in these areas. During an interview on 07/10/24 at 2:12 p.m., an administrative nurse (#6) agreed staff failed to code the MDS correctly for Residents #3, #13, #15, and #25. SECTION K: SWALLOWING/NUTRITIONAL STATUS The Long-Term Care Facility RAI Manual, revised October 2023, page K-10, states, ". . . K0520. Nutritional Approaches: Check all of the following nutritional approaches that apply . . . Performed while a resident of this facility and within the last 7 days . . . B. Feeding tube . . . C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) D. Therapeutic diet (e.g. low salt, diabetic, low	F 641		

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F 641	Continued From page 9 cholesterol) . . ." Review of Resident #1's medical record occurred all days of survey. The physician's orders identified a feeding tube, Osmolite (type of tube feeding formula), and a pureed (mechanically altered) diet. Resident #1's quarterly MDS, dated 04/05/24, identified a therapeutic diet, and failed to identify a feeding tube or a mechanically altered diet. During an interview on 07/11/24 at 9:20 a.m., a dietary manager (#3) agreed staff failed to code the MDS correctly for Resident #1.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		8/9/24

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F 657	Continued From page 10 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE COMPLAINT SURVEY COMPLETED ON 03/12/24. Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect residents' current status for 2 of 12 sampled residents (Resident #17 and Resident #25). Failure to update care plans limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care Plan-R/S [rehab/skilled], LTC [long-term care], Therapy & Rehab" occurred on 07/11/24. This policy, dated November 2023, stated, ". . . POLICY . . . Each resident will have an individualized, person-centered, comprehensive plan of care . . . Any problems, needs and concerns identified will be addressed through the use of departmental assets, the Resident Assessment Instrument (RAI) and review of the physician's orders. . . . This plan of care will be modified to reflect the care currently required/provided for the resident. . . ."	F 657	1. The care plan for Resident #25 was updated on 7-10-24 to include the fall mat at the bedside. The care plan for Resident #17 was updated on 7-24-24 to include the changes in his care needs. Re-education provided to clinical leadership team and licensed nurses by DNS on 7/18/24 regarding updating care plan with residents change of condition / change in treatment plan. 2. All residents have the potential to be affected. 3. Additional re-education will be provided by DNS to clinical leadership team and licensed nurses on the GSS “Care Plan-Rehab, Skilled” policy and procedure, specific to updating care plan to include resident’s individualized interventions to meet current needs by 8/9/24 or prior to next scheduled shift. 4. DNS or designee will audit 5 current residents care plan for accuracy 1 X / week for 4 weeks, then 1X / month for 2 months. Any deficient practice identified will be addressed immediately. Audit results will be submitted to QAPI Committee for review and recommendations 5. 8-09-2024	

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F 657	Continued From page 11	F 657		

- Review of Resident #17's medical record occurred on all days of survey. The current care plan stated, "The resident has an ADL [activities of daily living] self care performance deficit only in bathing, otherwise, is independent. Date Initiated: 11/03/2023 Revision on: 11/21/2023 . . ."

A quarterly Minimum Data Set (MDS), dated 06/02/24, identified the resident required setup or cleanup assistance for eating and partial/moderate staff assistance for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.

The facility failed to updated Resident #17's care plan to reflect the care needs and staff assistance required.

During an interview on 07/11/24 at 10:20 a.m., an administrative staff member (#1) confirmed staff failed to revise the care plan to reflect the changes in ADLs.

- Review of Resident 25's medical record occurred on all days of survey. The current care plan, dated 04/26/24, stated, ". . . The resident is at risk for falls R/T [related to] Osteoporosis and abnormalities of gait and mobility E/B [evidenced by] history of falls, hx [history] of femur fracture prior to admit. . . . Modify to maximize safety. . . ."

Observations on 07/09/24 and 07/10/24 showed a fall mat placed on the floor beside the resident's bed.

Review of progress notes showed the following:

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	355089	A. BUILDING _____ B. WING _____	C 07/11/2024

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GOOD SAMARITAN SOCIETY - PARK RIVER	301 SOUTH COUNTY ROAD 12B PARK RIVER, ND 58270

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F 657	Continued From page 12 *10/09/23 at 3:37 p.m., ". . . Encouraged to wait for staff to help to prevent another fall. . . . Falls mat @ [at] bedside." *02/22/24 at 10:59 p.m., ". . . Found resident sitting on the floor by her bed on top of the mat by her bed. . . ." *05/29/24 at 4:42 a.m., ". . . Steady on feet and will attempt to self transfer. Falls [sic] mat @ [at] bedside. . . ." Resident #25's care plan failed to address the use of a fall mat at bedside. During an interview on 07/11/24 at 10:26 a.m., an administrative staff member (#1) confirmed staff failed to revise the the care plan to reflect the use of a fall mat.	F 657		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/08/23. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received adequate supervision/assistance to prevent accidents for 1 of 1 sampled resident (Resident #15) observed	F 689	1. Staff #2 was re-educated on 7-18-24 on the use of the leg strap as care planned for Resident #15. 2. All residents care planned for the use of sit-to-stand lifts have the potential to be affected. 3. Re-education will be provided by the Director of Nursing to licensed nurses and	8/9/24

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F 689	Continued From page 13 during a sit-to-stand lift transfer. Failure to ensure proper use of a leg strap as care planned placed Resident #15 at risk for possible injury. Findings include: Review of the facility policy titled "Safe Resident Handling Equipment-Competency Validation Checklist" occurred on 07/11/24. This policy, dated March 2023, stated, ". . . Checks resident care plan or Kardex prior to transfer for type of equipment to be used, type and size of sling and amount of assistance required . . . If directed by care plan or location specific procedure, uses the shin/calf strap when the resident requires additional lower extremity support . . . Applies the shin/calf strap when the resident is in a seated position, before rising to a standing position. . . ." - Review of Resident #15's medical record occurred on all days of survey. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, muscle spasm, and polyneuropathy. The current care plan stated, ". . . TRANSFER - Transfer Between Surfaces: Use SS-M [sit-to-stand lift with medium sling] with leg strap, assist of 1 for transfers. . . ." Observation on 07/09/24 at 11:10 a.m., showed a certified nurse aide (CNA) (#2) transferred Resident #15 from the bed to the toilet using the sit-to-stand lift. The CNA applied the sling to the resident and fastened the buckle then attached the sling to the lift. The CNA cued the resident to hold onto the lift bars and to place their feet on the platform. The CNA lifted the resident to a standing position, transferred to the bathroom	F 689	CNAs on GSS Safe Resident Handling policy with competency checklist regarding providing care as per the care plans, specific to using the sit-to-stand lift / sling use by 8/9/24 or prior to next scheduled shift. 4. DNS or designee will conduct observation audits of 4 different staff members performing sit-to-stand transfers, verifying care is provided as per care plan (strap use). Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months. Any deficient practice observed will be addressed immediately. Audit results will be submitted to QAPI Committee for review and recommendations 5. 8-09-2024	

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F 689	Continued From page 14 and lowered to the toilet. After toileting, the CNA lifted the resident to a standing position, completed cares, and transferred the resident to the wheelchair. The CNA failed to apply the leg strap during transfers between surfaces. During an interview on 07/11/24 at 10:26 a.m., an administrative staff member (#1) confirmed the staff should apply the leg strap as care planned for the resident.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to ensure a medication error rate of less than five percent for 1 of 7 residents (Resident #7) observed during medication administration. Two medication errors occurred during staff administration of 25 medications, resulting in an eight percent error rate. Failure to properly prepare and administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of the facility policy titled "Medication: Insulin Administration, Insulin Pens, Insulin Pumps" occurred on 07/11/24. This policy, dated 12/14/23, stated, ". . . Insulin Pen . . . Remove	F 759	1. Staff #9 is currently on leave. Re-education provided to licensed nurses by DNS on 7/18/24 on the proper technique of insulin pen priming and wait time after injection to withdraw needle. 2. All residents receiving insulin have the potential to be affected. 3. Additional re-education provided to licensed nurses by DNS on GSS "Medication: Insulin Administration, Insulin Pens" specific to proper technique of insulin pen priming and wait time after injection to withdraw needle by 8/9/24 or prior to next schedule shift. 4. Audits of preparing and administering insulin will be done by the Director of Nursing or designee 1 X / week for 4 weeks, then 1 X / month for 2 months.	8/9/24

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F 759	Continued From page 15 the protective pull tab from the needle and screw it onto the pen . . . Remove both the plastic outer cap and inner 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. . . . Inject the dose into the chosen site. Be sure to wait about 6 seconds to ensure that the full dose has been delivered. . . ." Observation of medication administration on 07/10/24 at 7:43 a.m. showed a nurse (#9) prepared a Levemir (long-acting) insulin pen and a Fiasp (rapid-acting) insulin pen for Resident #7. The nurse applied a needle, dialed each pen to two units, and held each pen horizontally to prime the insulin pen. After injecting the insulin, the nurse (#9) removed the needle from the skin immediately. Failure to prime an insulin pen correctly and inject the insulin with proper technique may result in the resident receiving less than the full dose.	F 759	Any deficient practice observed will be addressed immediately. Audit results will be submitted to QAPI Committee for review and recommendations 5. 8-09-2024	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		8/9/24

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F 761	Continued From page 16 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure accurate labeling of medications in 1 of 2 medication carts (300/400 cart) observed during medication administration. Failure to obtain a label for an insulin pen and identify an open date may result in a resident receiving an incorrect or ineffective dose of insulin. Findings include: Review of the facility policy titled "Medication: Insulin Administration, Insulin Pens, Insulin Pumps" occurred on 07/11/24. This policy, dated 12/14/23, stated, ". . . Insulin Pen . . . Insulin pens must be clearly labeled with the name or other identifiers to verify that the correct pen is used on the correct person. . . . Verify provider order, the expiration date and the number of days the pen has been open. . . ." - Observation on 07/10/24 at 8:17 a.m. showed a nurse (#5) prepared Resident #15's Humalog	F 761	1. Insulin pens for Residents #15 and #136 are labeled with the resident name and open date. Licensed nurses were re-educated by DNS on 7/18/24 regarding proper labeling of insulin pens. 2. All residents using insulin pens have the potential to be affected. 3. Additional re-education to licensed nurses by the Director of Nursing on GSS "Medication: Insulin Administration, Insulin Pens" policy and procedure, specific to the requirement that all insulin pens must be clearly labeled with the resident name to verify that the correct pen is used on the correct resident, as well as the open date by 8/9/24 or prior to next scheduled shift. 4. DNS will audit all medication carts to verify insulin pens in use are properly labeled / dated. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months. Any deficient practice observed will be addressed immediately.	

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F 761	Continued From page 17 insulin pen for administration. The nurse obtained the pen from a bin labeled with the resident's name. The pen lacked a label with the resident's name or other identifying information and lacked an open date. - Observation on the morning of 07/10/24, during a check of insulin pens in the 300/400 wing medication cart, identified Resident #136's Tresiba (long-acting) insulin pen lacked an open date. During an interview on 07/10/24 at 8:30 a.m., a nurse (#5) stated, "Whoever opens a pen is supposed to date it when opened."	F 761	Audit results will be submitted to QAPI Committee for review and recommendations 5. 8-09-2024	
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 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	F 880		8/9/24

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F 880	Continued From page 18 facility assessment conducted according to §483.70(e) 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. §483.80(e) Linens.	F 880		

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F 880	Continued From page 19 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 for 2 of 2 sampled residents (Resident #1 and #3) observed with enhanced barrier precautions (EBP). Failure to practice infection control standards by ensuring staff use the proper personal protective equipment (PPE) has the potential to transmit infections to residents, staff, and visitors. Findings include: Review of the facility policy titled "Standard and Transmission-Based Precautions, All Service Lines" occurred on 07/11/24. This policy, revised 04/02/24, stated, ". . . Purpose . . . To prevent the spread of infection . . . Enhanced Barrier Precautions . . . Enhanced barrier precautions expand the use of PPE 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] . . . Enhanced barrier precautions are needed for . . . Residents with Indwelling Medical devices (. . . indwelling urinary catheters, feeding tubes . . .) . . ."	F 880	1. Re-education to staff provided by the Director of Nursing regarding Enhanced Barrier Precautions for Resident #1 and Resident #3 on 7-18-24. Personal Protective Equipment (PPE) supplies are now stocked in the therapy room. 2. All residents requiring Enhanced Barrier Precautions have the potential to be affected. 3. Additional re-education provided to staff by DNS on GSS “Standard and Transmission-Based Precautions” policy specific to enhanced barrier precautions and proper PPE use. Education provided by 8/9/24 or prior to next scheduled shift. 4. DNS or designee will conduct observation audits staff members providing care to resident on EBP for proper PPE. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months. Any deficient practice observed will be addressed immediately. Audit results will be submitted to QAPI Committee for review and recommendations 5. 8-09-2024	

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F 880	Continued From page 20	F 880		

- Review of Resident #1's medical record occurred on all days of survey. Current physician's orders included tube feeding formula/water flushes and gastrostomy (artificial opening into the stomach) tube site care daily and as needed (PRN).

Observation on 07/09/24 at 3:11 p.m. showed Enhanced Barrier Precautions signs on Resident #1's doorframe and on top of the supply cart in the room. A nurse (#4) performed hand hygiene and gloved, flushed Resident #1's feeding tube, administered a PRN medication, then flushed and capped the tube. The nurse removed the soiled dressing from the gastrostomy tube site, cleansed the area, applied a new dressing, and performed hand hygiene and glove changes where indicated. The nurse (#4) failed to wear a gown as required.

-Review of Resident #3's medical record occurred on all days of survey. The current care plan stated, ". . . The resident requires Enhanced Barrier Precautions (EBP) R/T [related to] indwelling medical device suprapubic catheter . . . Don gown and gloves when performing high contact care activities including: dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing, device care and/or use, and wound care. . . ."

Observation on 07/09/24 at 10:45 a.m. showed Resident #3 completing exercises with a restorative nursing aide (#7) in the therapy room. The aide proceeded to complete exercises with the resident's hands, shoulders, and feet. The aide (#7) failed to donn the appropriate PPE as

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F 880	Continued From page 21 required. Observation on 07/09/24 at 3:50 p.m., showed two certified nurse aides (CNAs) (#2 and #8) emptied Resident #3's catheter bag. The CNAs donned gloves, performed cares, doffed their gloves, sanitized their hands, and exited the room. The CNAs failed to don gowns as required. During an interview on 07/11/24 at 10:26 a.m., an administrative staff (#1) confirmed staff should don PPE as required.	F 880		