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 _____	11/21/2019

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 11/18/19 and concluded 11/21/19.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 15 sampled residents (Resident #37). Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate care plan approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.16), dated October 2018,	F 637	1. Significant Change MDS was completed on resident #37 on 12/5/2019 2. All residents have the potential to be affected. 3. Education to the care plan team on Recognizing Significant Change on Residents was completed on December 10, 2019 by the Good Samaritan Society Clinical Compliance Specialist. The care plan team will meet prior to formal care plan meetings to discuss changes that have been made on the MDS and care plan from prior MDS. The team will discuss if a significant change is warranted. 4. Monitoring will be done by the MDS	12/23/19

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

Electronically Signed | 12/10/2019

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 _____	11/21/2019

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 637	Continued From page 1 page 2-22 stated, ". . . A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . This may include two changes within a particular domain (e.g., [for example] two areas of ADL [Activities of Daily Living] decline or improvement. . . . Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since the last assessment . . ." Review of Resident #37's medical record occurred on all days of the survey and identified a diagnosis of dementia. A quarterly Minimum Data Set (MDS), dated 07/09/19, identified the resident required limited assist with dressing, supervision with toileting, and always continent of bowel and bladder. A quarterly MDS, dated 10/09/19, identified the resident required extensive assistance with dressing and toileting, and occasionally incontinent of bowel and bladder. The current care plan stated, ". . . The resident has an ADL self care performance deficit R/T [related to] dementia E/B [evidenced by] need for assist with ADLs . . ." Review of Resident #37's medical record identified the following progress note: * 10/22/2019 - "Resident continues to use supervision for bed mobility, transfers, and locomotion. Extensive assist was used several	F 637	Coordinators or others as assigned by random audits of MDS coding weekly for 4 weeks, then monthly for 4 months, then as deemed necessary by the Quality Assurance 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 _____	11/21/2019

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 637	Continued From page 2 times for dressing and toileting which was a decline. . ." During interview on 11/21/19 at 10:28 a.m., an administrative nurse, (#1) stated "We [the facility] follow the RAI manual regarding completing significant change assessments and we would complete when there are two or more areas of change with ADLs."	F 637		
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 by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 2 of 15 sampled residents (Resident #18 and #22) and 2 of 3 closed records (Resident #46 and #47). Failure to accurately complete Section A (identification) and Section K (nutrition) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION A: IDENTIFICATION The Long-Term Care Facility RAI User's Manual,	F 641	For residents #46, 47, 18 and 22, MDS modifications were completed by December 6, 2019. 2. All residents have the potential to be affected. 3. Education to care plan team was completed on December 10, 2019 by the Good Samaritan Society Clinical Compliance Specialist. 4. Discharge MDSs will be audited for accuracy by the MDS Coordinators or designee monthly for one month, then quarterly for one quarter, then as deemed necessary by QA Committee. K0200B and K0300 will be audited by the Certified Dietary Manager or designee monthly times one, then quarterly times one quarter and then as the Quality Assurance Committee deems necessary.	12/23/19

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 _____	11/21/2019

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 641	Continued From page 3 revised October 2018, page A-29 stated, ". . . Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living or group home . . . Code 02, another nursing home or swing bed: if discharge location in a institution that is primarily engaged in providing skilled nursing care and related services . . . Code 03 , acute hospital: if discharge location is an institution that is engaged in providing . . . therapeutic services for medical diagnosis, and the treatment and care . . . sick persons. . . ." - Review of Resident #46's medical record occurred on all days of survey. The quarterly MDS, dated 10/20/19, showed staff coded A2100 with an 02 which indicated the resident was discharged to another nursing home. Review of nursing notes 09/30/19 to 10/20/19 showed Resident #46 was discharged to an acute hospital with a diagnoses of pneumonia. - Review of Resident #47's medical record occurred on 11/21/19. The discharge MDS, dated 09/16/19, showed staff coded A2100 03 which indicated the facility discharged the resident to an acute care hospital. Review of nursing notes from 08/16/19 to 09/16/19 showed the facility discharged Resident #47 to his home. SECTION K: NUTRITION The Long-Term Care Facility RAI User's Manual, revised October 2018, page K-5-6 stated, ". . . Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days	F 641		

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 _____	11/21/2019

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 641	Continued From page 4 or if information about prior weight is not available . . . Code 2, yes, not on physician prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days and the weight loss was not planned and prescribed by a physician . . ." - Review of Resident #18's medical record occurred on all days of survey. The resident's current MDS, dated 09/03/19, identified weight loss. Resident #18's weight at the time of the MDS was 118 pounds (lbs.) (One month prior, on 07/31/19, Resident #18's weight was 120.7 lbs (a loss of 2.24%, not significant). Six months prior, on 03/06/19, Resident #18's weight was 130.2 lbs (a loss of 9.37%). - Review of Resident #22's medical record occurred on all days of survey. The resident's current MDS, dated 09/08/19, identified weight loss. Resident #22's weight at the time of the MDS was 173 lbs. One month prior, on 08/05/19, Resident #22's weight was 170 lbs (a loss of 1.7%, not significant). Six months prior, on 03/04/19, Resident #22's weight was 153 lbs (a gain of 11%). During an interview on 11/20/19 at 3:47 p.m., a supervisory nurse (#1) stated Residents #18 and #22 did not have a weight loss, and staff incorrectly coded the MDS.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		12/23/19

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 _____	11/21/2019

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 656	Continued From page 5 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced	F 656		

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 _____	11/21/2019

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 656	Continued From page 6 by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 10/31/18. Based on record review, facility policy and staff interview, the facility failed to develop a comprehensive care plan for 2 of 15 sampled residents (Resident #19 and #34). Failure to develop a care plan may negatively impact the resident's quality of life. Findings Include: Review of facility policy titled "Care Plan" occurred on 11/21/19. This policy, revised November 2016, stated, "Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized, person-centered, comprehensive plan of care . . . directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. Through the use of departmental assessments, the Resident Assessment Instrument and review of the physician's orders, any problems, needs and concerns. . . . " - Review of Resident #19's medical record occured on all days of the survey. The quarterly Minimum Data Set (MDS), dated 09/06/19, identified a diagnosis of heart failure, and the use of a diuretic, (a medication to remove extra fluid from the body). Review of Resident #19's care plan occurred on 11/21/19. The care plan failed to identify Resident #19's need for physician	F 656	1. Care plans were amended for Residents #19 and 34. 2. All residents with orders for high risk medications and/or a history of urinary tract infections are at risk. 3. Education provided by Staff Development Coordinator on December 17, 2019 to nurses for care planning of high risk medication, signs, and symptoms of adverse reactions. Education also provided for the care planning and importance of for history of urinary tract infections. 4. Residents using diuretic medications and experiencing urinary tract infections will be audited by the Unit Coordinators, DON or other assigned individuals weekly times 4 weeks, monthly times two months, then quarterly for one quarter, then as the Quality Assurance Committee deems necessary.	

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 _____	11/21/2019

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 656	Continued From page 7 prescribed diuretic or signs/symptoms of adverse reactions (such as increased urination, thirst, or dizziness) to diuretic use. - Review of Resident #34's medical record occurred on all days of the survey. The quarterly MDS, dated 10/16/19, identified as having a urinary tract infection (UTI) in the past 30 days. The care plan stated, ". . TOILET USE: Wears incontinence product. Uses bed pan. . . ." A fax dated 11/16/19 sent to the provider stated, ". . . Resident continues to c/o [complain of] burning with urination and discomfort for some time now. Can we maybe check a UA [urinalysis] to get ahead of infection rather than wait for her usual delusions that come with a UTI for her. . . ." Resident #34's care plan failed to address recurring UTI's, signs and symptoms to observe and interventions to prevent UTI's. During an interview on 11/21/19 at 11:20 a.m., an administrative nurse (#1) agreed staff failed to develop and individualize Resident #34's care plan for recurring UTI's.	F 656		
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, review of facility policy, and staff interview, the facility failed to ensure residents received the necessary services for 3 of 15 sampled residents (Resident	F 677	1. For Residents #11 and 37 the personal care of shaving was completed on 11/21/2019. Care plan revised to address refusals. Resident #31 order	12/23/19

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 _____	11/21/2019

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 8 #11, #31, and #37) who required staff assistance with personal hygiene and dressing. Failure to provide assistance with dressing and personal hygiene may result in decreased self esteem and a decreased quality of life. Findings include: Review of facility policy titled "Activities of Daily Living", occurred on 11/21/19. This policy, revised June 2014, stated, "Any resident who is unable to carry out activities of daily living [ADLs] will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. . . . ADLs are those necessary tasks conducted in the normal course of a resident's daily life. . . . 1. General Personal, Daily Hygiene/Grooming: Care of hair, hands, face, shaving, . . . 3. Dressing: selecting, obtaining and putting on, fastening and taking off items of clothing including braces and prostheses. . . . " - Observations on all days of survey showed Resident #11 in activity room, dayroom, or laying in bed unshaved with visible facial hair noted to face, chin, and neck. Review of Resident #11's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 8/16/19, identified Resident #11 as needing extensive assist of 1 for ADLs. Resident #11's care plan stated, "Personal Hygiene: Resident requires one staff assist with personal hygiene. Wears glasses. May refuse personal care at times. Reapproach later when refuses." Review of certified nursing assistant (CNA) task documentation for November 18-20, 2019 lacked	F 677	received on 11/21/2019 to discontinue compression stockings. Care plan revised to reflect change. 2. All residents have the potential to be affected. 3. Education to nursing department staff will be provided by the Staff Development Coordinator on December 17, 2019 on personal care ADLs and documentation. 4. Audit of residents facial hair, using support stockings and documentation will be completed by the QA Coordinator or designee twice weekly for 1 month. Then monthly times 3 months then as deemed necessary by QA 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 _____	11/21/2019

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 9	F 677		

documentation of resident refusal of personal hygiene.

During interview on 11/21/19 at 11:55 a.m., an administrative nurse (#2) stated, "The CNAs say he slaps at them when they try to shave him. That's why he isn't shaved." The administrative nurse agreed staff should document any refusals in the medical record.

- Review of Resident #37's medical record occurred on all days of survey identifying dementia as a diagnosis. The quarterly MDS, dated 10/19/19, identified limited assistance required for personal hygiene. Resident #37's care plan stated, ". . .The resident has an ADL self care performance deficit R/T [related to] dementia E/B [evidenced by] need for assist with ADLs . . ."

Observations on all days of survey showed Resident #37 in dining room, front lobby, or laying in bed unshaved with visible facial hair noted to face, chin, and neck.

During an interview on 11/21/19 at 10:00 a.m., an administrative nurse (#2) confirmed she expects staff to shave residents daily and notify the nurse if a resident refuses so staff can document this in the resident's record.

- Review of Resident #31's medical record occurred on all days of survey. The current MDS, dated 10/08/19, identified extensive assistance from one person for dressing. Current physician's orders stated, ". . . Compression stockings BLE [bilateral lower extremeties] due to increased edema. . . . in the morning for incrased [sic]

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 _____	11/21/2019

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 10 edema . . ." Resident #31's care plan stated, ". . . The resident has chronic dependent edema R/T [related to] cardiovascular disease/decreased circulation. Feet and lower extremities cool to touch. Hx. [history] DVT [deep vein thrombosis] LLE [left lower extremity] . . . SUPPORT STOCKINGS: Apply and/or remove, on AM off HS [bedtime]. . . ." Throughout the survey, observations showed Resident #31 either up in her wheelchair or lying in bed without compression stockings in place. During an interview on the morning of 11/21/19, a managerial nurse (#3) identified staff would re-evaluate Resident #31's need for compression stockings.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed	F 686	1. Resident #31 pressure injury was closed on November 13, 2019. Resident	12/23/19

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 _____	11/21/2019

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 686	Continued From page 11 to provide the necessary care and services for 2 of 3 sampled residents (Resident #31 and #44) with a current or recently healed pressure ulcer. Failure to routinely assess, monitor, and measure pressure ulcers and ensure consistent implementation of interventions and treatment may result in delayed healing of the pressure ulcers. Findings include: Review of the facility policy titled "Pressure Ulcer Practice Guidelines" occurred on 11/21/19. This policy, revised September 2016, stated, ". . . Wound Assessments . . . The location should have a system in place for daily monitoring of pressure ulcers with accompanying documentation from the Wound Data Collection UDA when a complication or change is identified. . . ." - Observation on 11/19/19 at 10:26 a.m., during perineal cares, identified Resident #44 had two open areas to the coccyx, the lower area had a white wound bed. A staff nurse (#6) applied a new foam dressing to the open areas on Resident #44's coccyx and stated "it's deeper". When asked how often staff measure and document the pressure ulcers, staff nurse (#6) stated, "every week". Review of Resident #44's medical record occurred on all days of survey. The quarterly Minimum Data Set, dated 10/26/19, showed a diagnosis of pressure ulcer of sacral region stage three. A physician's order dated 11/16/2019 stated, "Cleansed [sic] coccyx wound with NS [normal saline], apply protective foam dressing.	F 686	#44 wound data collection and measurements tools were initiated. 2. Residents with pressure injuries are at risk. 3. Education for nurses on pressure injury assessment completed by Staff Development Coordinator on December 17, 2019. 4. Audits of daily completion of Wound Data Collection and Weekly RN assessment will be done by the DON or others as assigned weekly times two weeks, monthly times two months, then quarterly for two quarters, then as deemed necessary by QA 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 _____	11/21/2019

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 686	Continued From page 12 Change three days a week/PRN [as needed] one time a day every Tue [Tuesday], Thu [Thursday], Sun [Sunday] for ulcer on coccyx." Review of nursing documentation showed the following: *10/15/2019 at 3:05 p.m., "2 cm [centimeter] x 0.5 cm x 0.2 cm periwound area is dark purple in color. Apply calmoseptine to wound edges and cover with Mepilex Sacrum Border dressing on coccyx. Change dressing q 3 [every three] days and prn." *10/22/2019 at 10:51 a.m., "5.5 cm x 2 cm x 0.2 cm no change to treatment." *10/26/2019 at 6:29 a.m., "Resident has new opening on coccyx approx. [approximately] 1.5 cm in length. New opening is below existing pressure sore. Writer applied calmoseptine and included in covered area currently being treated for daily bandage change." *10/28/2019 at 11:33 a.m., a note from the hospice nurse stated, ". . . Observed Kennedy ulcer [a sore that develops rapidly during the final stages of a person's life] to coccyx, would [sic] edges are defined, slough noted to wound bed, observed a 2nd open area below Kennedy ulcer that is 1.5 cm in diameter, wound bed is pink, scant drainage, edges are defined and intact, placed foam adhesive dressing and will change q 3 days and prn. . . ." *11/04/2019 at 10:43 a.m., "1.3 cm x 1.1 cm bottom. . . .top 2.1 cm x 1.9 cm." *11/15/2019 at 3:35 a.m., "1.5 cm x 2.5 cm x 0.2 cm top, bottom L [length] =1.2 cm and W [width] = 1cm." The medical record lacked evidence of daily assessments (the Wound Data Collection tool)	F 686		

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 _____	11/21/2019

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 686	Continued From page 13 completed by staff from October 15, 2019 to November 21, 2019 and weekly documentation of the pressure ulcer measurements. During interview on 11/21/19 at 11:55 a.m., an administrative nurse (#2) confirmed staff failed to provide weekly documentation of pressure ulcer measurements in Resident #44's medical record as she would expect. - Review of Resident #31's medical record occurred on all days of survey. The record identified a Stage III pressure ulcer to the resident's left buttocks which healed on 11/14/19. Nurses' notes identified the following: *10/2/19 at 4:56 p.m.: ". . . E-mail communication with [company name] wound care nurse re: [regarding] OA [open area] on buttocks and rash/raw areas of buttocks and peri-area. Recommendations provided and plans to observe and give recommendations on Friday 4th [October 4th]. No new orders at this time. . . ." *10/4/19 at 10:45 a.m.: ". . . Resident's wounds to left buttock were assessed per [wound care nurse] from [company name]. Her recommendations for treatment sent to MD [medical doctor] for approval. . . ." The wound care progress note, dated 10/04/19, stated, ". . . Wound 1 buttock, left . . . Pressure Ulcer - Stage III . . . Treatment Intervention: Cleanse left buttock wound per facility protocol. Apply collagen moistened with anasept (mix to a dry paste) to wound bed. Cover with bordered super absorbent dressing. Change dressing daily. . . ."	F 686		

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 _____	11/21/2019

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 686	Continued From page 14 The medical record lacked evidence of daily dressing changes until 10/15/19, when staff entered the order into the medication administration record and documented the dressing change daily. The record also lacked evidence of daily assessments (the Wound Data Collection tool) completed by staff from October 4, 2019 to November 14, 2019. During an interview on the afternoon of 11/20/19, a supervisory nurse (#1) identified staff should have completed daily assessments on Resident #31's pressure ulcer.	F 686		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure timely physician response	F 710	1. Hospice resident #32 expired on 11/25/2019.	12/23/19

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 _____	11/21/2019

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 710	Continued From page 15 to changes in resident's weight/condition for 1 of 15 sampled residents (Resident #32). Failure to ensure the physician responded in a timely manner may result in a delay of treatment and further weight loss for Resident #32. Findings include: Review of Resident #32's medical record occurred on all days of survey. Diagnoses included hemiplegia and hemiparesis following a cerebral vascular accident (CVA), type 2 diabetes mellitus and dysphagia. The care plan stated, ". . . The resident has nutritional problem or potential nutritional problem r/t [related to] recent CVA w/ [with] dysphagia requiring puree, nectar thick liquids and reduced ability to feed self. . . ." The record identified the following weights: * 10/8/2019 - 152.2 pounds (lbs) * 10/18/2019 - 153.0 lbs * 10/24/2019 - 151.7 lbs * 10/31/2019 - 153.0 lbs * 11/7/2019 - 141.7 lbs * 11/14/2019 - 139.0 lbs Resident #32's progress notes stated the following: * 11/7/2019 14:22 ". . . Communication/Visit with Physician Note Text: Fax sent to [clinic name] regarding residents weight loss. Also notified that resident had a decline in cognitive status this past week-hollering out numbers frequently and calling out for her husband this morning. . . ." * 11/19/19 01:11 PM ". . . On 10/18/2019, the resident weighed 153 lbs. On 11/14/2019, the resident weighed 139 pounds which is a -9.15 %	F 710	2. Residents experiencing significant weight change are at risk. 3. Education to nurses will be provided by Staff Development Coordinator on December 17, 2019 to use the Response required box on Fax to Physician Form to allow for response. Discussion held with medical provider on December 05, 2019 regarding importance of responding to significant weight change faxes. 4. Audits of weight change notification faxes will be completed by HIM, DON or others as assigned weekly for three weeks, monthly times two, then quarterly times one then as deemed necessary by the Quality Assurance 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 _____	11/21/2019

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 710	Continued From page 16 Loss. . . ." The record included a fax sent to the physician on 11/07/19 which stated, "10/31 weight 153 pounds, today 141.7, eating 25%, have tried supplements, resident does not like them. Drinking fluids frequently. Decline in cognitive status this past week-hollering out numbers and calling "[husband's name], come over here." (Husband who is passed away). . . ." During an interview on 11/21/19 at 10:30 a.m., an administrative nurse (#5) confirmed the facility had not received any consultation from the physician following the fax sent to him on 11/07/19. The facility failed to ensure the physician provided consultation and/or treatment regarding Resident #32's significant weight loss.	F 710		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		12/23/19

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 _____	11/21/2019

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 883	Continued From page 17 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced	F 883		

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 _____	11/21/2019

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 883	Continued From page 18 by: Based on record review, review of facility policy, and staff interview, the facility failed to document and provide education to residents and/or their legal representatives regarding the benefits and potential side effects of receiving the influenza vaccine for 5 of 5 sampled residents (Resident #7, #18, #22, #34, and #44) reviewed for immunization status. Failure to provide and document education regarding the benefits and potential side effects of the influenza immunization prevents residents to exercise his or her right to make informed choices. Findings include: Review of the facility policy titled "Immunizations for Residents" occurred on 11/20/19. This policy, revised July 2016, stated, "Annual Influenza Vaccination . . . Inform resident or resident representative each year when the influenza vaccinations will be given and provide the Vaccination Information Statement . . . for the current year. . . ." Review of Resident #7, #18, #22, #34 and #44's medical record occurred on 11/20/19. The record showed all five residents received the influenza vaccine in October, 2019. The record lacked evidence the facility provided education to the residents and/or their legal representatives regarding the benefits and potential side effects of the influenza immunization prior to the vaccine administration. During interview on 11/20/19 at 9:15 a.m., an administrative nurse (#6) verified the facility failed to document influenza education to the resident	F 883	1. Late entries were completed for residents #7, 18, 22, 34 and 44, stating education was provided to name of responsible party and date. 2. List of all residents that education had been provided to and all residents with admission date after November 21, 2019 have the potential to be affected. 3. Licensed Nurse giving immunizations was educated on November 27, 2019 by Good Samaritan Society Rehab/Skilled Consultant regarding Good Samaritan Society Immunization for Residents policy and procedure specific to documentation of the name of the person receiving the education in the notes section of the immunization tab. 4. Audit for documentation of persons receiving education on benefits and side effects of vaccine will be done by the Infection Preventionist or other designated individuals one time for one month, one time quarterly for one quarter, then as deemed necessary by the Quality Assurance 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 _____	11/21/2019

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 883	Continued From page 19 and/or their legal representative.	F 883		