STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355089	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/14/2026

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

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F0000	INITIAL COMMENTS The Centers for Medicare and Medicaid Services (CMS) conducted a comparative Federal Monitoring Survey (FMS) 1/13/26 through 1/14/26. Refer to State Survey Agency (SSA) Event ID 1DC37E-H1. Deficiencies were cited and 1 Facility Reported Incident (FRI) was investigated. Census: 42 IJ Addition: On 1/14/26 at 9:15 AM, an Immediate Jeopardy was identified for F600 and F610 A removal plan was accepted, and the Immediate Jeopardy was removed on 1/14/26 at 7:31 PM.	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure the resident was free from abuse when Resident (R)2 told Licensed Practical Nurse (LPN)1 that Certified Nursing Assistant (CNA)1 hit him on the head, pulled his ears and threw him onto the bed. Additionally, the facility failed to ensure R1 was free from abuse when R2 was found rubbing R1's breast and abdomen area. These failures have the potential to	F0600	1. For R2 no longer resides in facility. R2 passed away on 1/9/26. The Investigation team (Administrator, Director of Nursing and Social Services) reviewed GS Abuse and Neglect Policy on 1/14/26. For R1 no longer resides in facility. R1 passed away on 10/24/25. Investigation team (Administrator, Director of Nursing and Social Services) reviewed GS Abuse and Neglect Policy 1/14/26. 2. For all other residents that have the potential to be affected by the same deficient practice, the facility will ensure residents are free from abuse and neglect. Facility employees will report allegations of abuse and neglect to their immediate supervisor. The facility investigation team (Administrator, Director of Nursing and Social Services) will review all allegations of abuse and neglect and follow reporting protocols according to GS Abuse and Neglect Policy and the ND Memorandum Reporting. 3. In-Service Training: Director of Nursing and Administrator provided education for all staff on 1/14/26, to report to their immediate supervisor all allegations of abuse and neglect per GS Abuse and Neglect Policy. The GS RCSD provided education 1/14/26 to facility investigation team (Administrator, Director of Nursing and Social Services) to review all allegations of abuse, and neglect and following investigation and reporting protocols per GS Abuse and Neglect Policy and ND Memorandum Reporting.	

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F0600 SS = SQC-J	Continued from page 1 affect all residents in the facility. The facility reported census was 42. The Administrator (NHA) was notified of the Immediate Jeopardy (IJ) on 1/14/26 at 9:15 AM. The facility submitted an acceptable IJ Removal Plan on 1/14/26 at 3:09 PM. The Regional Office (RO) Surveyor was able to verify implementation of the removal plan and remove the immediacy on 1/14/26 at 7:31 PM. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "G". Removal Plan: “CNA 1 suspended until investigation 1/14/26 completed. All current residents have been interviewed and all responded feel safe with no concerns with care provided. All non-interviewable residents observed to be at baseline. All staff on duty were interviewed and denied observing or hearing a co-worker being verbally, physically, mentally abusive to residents. All off duty staff will be interviewed by phone today 1.14.26. New facility process: IDT will review progress notes each business day with follow up as indicated.” “Abuse and Neglect Policy and Procedure reviewed. No policy changes.” “All staff educated on [Facility Name] abuse and neglect policy and procedure specific to recognizing allegations of abuse and immediately reporting to facility investigative team (administrator [NHA], DNS [Director Nursing Services] or Social Service Designee [SSD] and new facility process above.” Findings include: I. Review of R2’s Care Plan revealed R2 was admitted to the facility on 6/3/25. Pertinent diagnoses included, Chronic heart failure, hypertension (high blood pressure), epilepsy (seizure disorder), traumatic subdural hemorrhage (bruise on the brain), generalized anxiety disorder, major depressive disorder, traumatic brain injury, unspecified psychosis, altered mental status and dementia . The Quarterly Minimum Data Set (MDS – federally mandated assessment), with an assessment reference date (ARD) of 11/13/25, revealed the resident had moderate cognition impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The assessment further revealed R2 was	F0600	Continued from page 1 New Facility Practice- Facility investigation team (Administrator, Director of Nursing and Social Services) will notify GS Rehab Clinical Services Director and/or GS Senior Director of all allegations of abuse and neglect to verify investigation and reporting criteria. 4. Audit: The DNS or designee will complete audits to monitor allegations of Abuse and Neglect have been reviewed, investigated and reporting to SSA as per GS Abuse and Neglect Policy and the ND Memorandum for reporting. Audits will be completed weekly x 4, monthly x 3, and quarterly x 1. Audit findings will be submitted to Quality Committee for review and further recommendations. 5. Completion date: 1/22/2026	

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F0600 SS = SQC-J	Continued from page 2 dependent on staff for rolling in bed and used a wheelchair. The assessment also revealed that R2 required maximum assistance with bed to chair transfers and transitioning from sitting to standing. Further review of R2's chart revealed that R2 died in the facility on 1/9/26. Review of R2's progress note dated 11/23/25 at 4:14 PM by LPN1 revealed, "Resident in chapel. Approached resident and resident stated " I don't want to be beat up anymore. Please don't let them. That black guy (NOC [night shift] CNA) he hit me on the head the other night and kept hitting me. And then he picked me up off the floor and threw me into bed." Resident began to cry. " He's always saying he's gonna pull my ears and then he does. " When asked if he felt safe resident replied "No." Asked if it was just the black guy or other staff and resident replied "just [CNA1 name] (black NOC CNA)." When asked if resident felt comfortable with [CNA1 name] providing cares, resident replied 'NO. please don't let him hurt me anymore." Reassured resident that nurse would pass on for [CNA1 name] not to be caretaker this evening. Message left for SS [SSD]." Review of R2's progress note dated 11/23/25 at 4:35 PM by Registered Nurse (RN)1 revealed, "Resident states that about 1 week ago a male caregiver wanted to put him to bed, but resident did't [sic] want to go to bed so the male caregiver threw him into bed. 2 caregivers are providing all cares for resident at this time." During an interview on 1/13/26 at 1:22 PM, R3 said that staff treats her fine and no one has ever said bad things to her or has ever hurt her. During an interview on 1/13/26 at 1:49 PM, R7 and R7's family member said that staff treated R7 kindly and no one has ever been rough and R7 had never been hurt. During an interview on 1/13/26 at 2:24 PM, R8 and R9 said staff had never hurt them. During a concurrent observation and interview on 1/13/26 at 2:32 PM in R5 and R6's room, CNA1 opened the door abruptly without knocking and came into the room. CNA1 said sorry and then continued to open up R5's dresser drawer and removed a phone charger and cord and plugged it into the wall by R5's bed. R6 was sitting on the edge of R5's bed and did not say anything. CNA1 then left the room and closed the door. R6 then said to surveyor that CNA1 was very bossy and very manipulative. R6 said that CNA1 had never hurt her but	F0600		

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F0600 SS = SQC-J	Continued from page 3 she feels that he is pretending to be someone he is not. R6 said that she has “utter contempt for him.” R6 denied that he had ever done anything to her. R5 said that CNA1 takes care of her well but today she asked him to put on her pants and he told her no. She said that she asked him again and he said no. R5 said she then told him to leave and then CNA1 laughed and said he was just playing with her and helped her. During an interview on 1/13/26 at 2:47 PM, the SSD stated if a someone came to her regarding abuse she would report to the “higher ups” and assist in the investigation. The SSD stated that there was no staff to resident abuse allegations that she was aware of. During a telephone interview on 1/13/26 at 3:43 PM, LPN1 said that R2 had made comments to her that someone was mean to him. LPN1 said that R2 said a staff member was rough with him and would kind of push him around when they would turn him and that the staff member would pull on him. LPN1 said that R2 told her that the staff member that did this was CNA1. LPN1 said that there were multiple times that R2 would “get on this kick where he would say those things.” LPN1 said R2 told her about two to three times about these concerns around late October to early November and she reported these to the Director of Nursing (DON), NHA, and SSD about the comments. LPN1 said that she left a voicemail for the SSD on her phone regarding the abuse allegation and notified the DON and NHA in person the next day she worked which was either Monday or Tuesday. LPN1 said she should have notified them immediately about the abuse concerns and that no other residents had voiced concerns about CNA1. During an interview on 1/13/26 at 4:10 PM, the DON said that her role in any suspected abuse is that someone better let her know immediately. The DON said that she would meet with the IDT (interdisciplinary team) and come up with a plan and put into place what needed to be done regarding interventions. The DON said that she would make sure both parties are safe and assess to see if they needed to go to the ER if there was an abuse concern. The DON said that there is a list for the facility of whom to contact for each event and what to do. The DON said there were no concerns of any staff to resident abuse allegations and if there was a concern she would investigate and make sure the resident was safe. During a telephone interview on 1/13/26 at 4:17 PM, RN1 said that if she suspected any type of abuse she would report the concern to her supervisor and if someone was in immediate harm’s way she would make sure they were	F0600		

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F0600 SS = SQC-J	Continued from page 4 safe. RN1 said that the progress note on 11/23/25 regarding R2 saying that a male caregiver threw him into bed and he was on two person cares (2 staff members providing care to resident) was maybe because there were some accusations made. RN1 said that because two person cares were already implemented, she thought the allegations had already been reported. During an interview on 1/13/26 at 4:28 PM, the NHA said there were no staff to resident abuse allegation that she was aware of. The NHA said that if a staff to resident abuse allegation did come up, staff should tell the NHA or the DON immediately. When the surveyor asked the NHA about R2 and the abuse concerns he brought up to LPN1 and RN1, the NHA said that there were comments made by R2 of a staff member hurting him but R2 would also want CNA1 to help him. The NHA said there was no bruising or anything noted on R2. NHA said that R2 would say he did not like CNA1 and then by the evening he said he felt safe and would want him to help him. The NHA said that they talked to CNA1about R2's concerns and he did not have anything to add. The NHA said that R2 had on his care plan for two people to assist him at all times. The NHA said that when she spoke to R2 regarding CNA1 that R2 said he liked him and could not give her examples regarding the concerns of CNA1. The NHA said that she did not document anything regarding allegation as she is "not nursing and she is not good about documenting but she probably should." The NHA said she cannot find where the two person cares are documented in R2's care plan. The NHA said that when R2 made the statements to the staff member, she would expect that "they" would eliminate CNA1 from his cares to ensure his safety. The NHA said that R2 was more "needy" at night and that this would be something that should be investigated but she does not have anything documented. The NHA said that it would not be appropriate for CNA1 to provide cares to other residents until the investigation was complete. The NHA said it is unknown if CNA1 continued to work but she would find out. Review of an unnamed and undated document provided by the facility revealed in pertinent part, for physical contact or sexual abuse regarding Resident to Resident, Staff to Resident or Allegation of sexual contact a call should be made to the NHA and DON. RO Surveyor requested all grievances and incident reports from the facility on 1/13/26 that were reported from September 2025 through present. NHA provided RO Surveyor with requested items on 1/13/26. Review of facility grievances and reported incidents provided to surveyor from September 2025 through present lacked any	F0600		

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F0600 SS = SQC-J	Continued from page 5 documentation of staff to resident abuse allegation from 11/23/25. During an interview on 1/14/26 at 8:41 AM, the NHA provided the surveyor a grievance form that was not provided with grievance documents from the previous day. The NHA said that R2 was moved to an assist of two staff members on Saturday 11/22/25 before R2 reported the incident to LPN1 and RN1. The NHA said that the SSD was trying to interview R2 but R2's sodium was low. The NHA said that R2 would make different allegations in the evening versus day times and he was quick to sexualize nurses. The NHA said that LPN1 did not follow the right process and she had spoken with her. The NHA said that the initial abuse allegation concern had come up Friday and then came to leadership on Monday. The NHA said that LPN1 was a newer nurse and that she may not have recognized potential abuse because it was different than Resident to Resident abuse. Review of document titled, Suggestion or Concern, last reviewed 11/13 dated 11/23/25 revealed in part, "Resident [R2's name] verbalized concern [with] Black NOC CNA (CNA1's name) Has been making accusation about cares since Friday evening and was put on assist of two. Will cont (continue) 2 assist and monitor" The document further revealed this was reported by LPN1 and written by the DON. Under the Investigation section of the Suggestion or Concern document the following was documented. "Visited [with] [CNA1's name], he stated provided cares of assist of [two] always because of behaviors. Attempted to interview [R2's initials] x 2- See prog (progress) note. Interviewed 5 residents- see audit sheet." This section was signed by the DON and the SSD and dated 11/24/25. The Resolution section of the document revealed, "Continue with 2 staff for personal cares in private/residents room at all times. Verbal education to staff for Documentation & leadership notification of Resident concerns." This section was signed by the DON and dated 11/26/25. Review of R2's Progress Note dated 11/24/25 at 1:51 PM by the SSD revealed, "Writer attempted to interview resident on weekend report, unable to wake resident up and question. Will continue to follow up." Review of R2's Progress Note dated 11/25/25 at 5:18 PM by the SSD revealed, "Writer discussed with resident previous concerns brought forward. Listen and validated concerns. Will continue with care plan of assist of 2 for resident and staff safety." Review of R2's Care Plan revealed R2 requires assist of two for dressing and undressing and with bathing. This	F0600		

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F0600 SS = SQC-J	Continued from page 6 care plan area was dated that it was initiated on 1/13/26 which was four days after R2 died. Review of R2's Skin Observation Log revealed that R2 did not have a skin assessment performed from 9/20/25 through 12/14/25. Review of R2's medical chart lacked any documentation that R2's family or medical provider were notified of abuse allegation. During an interview on 1/14/26 at 12:32 PM, the Regional Clinical Services Director (RCSD) said CNA1 was suspended today pending the investigation. During a telephone interview on 1/14/26 at 1:01 PM, CNA1 said that he helped R2 once in a awhile. CNA1 said that no one had accused him before of being rough with any patient. CNA1 said that one time R2 was upset with CNA1 because CNA1 was feeding another resident and R2 said he had to go to the bathroom. CNA1 said that every accusation that R2 made, CNA1 said he was not there at that time. CNA1 said that he was never suspended from caring for residents During an interview on 1/14/26 at 3:15 PM, the RCSD said that R2 did not have a skin or trauma assessment completed after the incident on 11/23/25. Review of the facility's nursing schedule of days worked revealed in pertinent part that CNA1 worked on the following dates during the evenings and nights: 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/26/25, 11/27/25, 11/28/25, 11/29/25, 11/30/25, 12/1/25, 12/2/25, 12/3/25, 12/5/25, 12/6/25, 12/7/25, 12/8/25, 12/11/25, 12/12/25, 12/13/25, 12/14/25, 12/15/25, 12/16/25, 12/17/25, 12/18/25, 12/19/25, 12/20/25, 12/21/25, 12/22/25, 12/24/25, 12/25/25, 12/26/25, 12/27/25, 12/28/25, 12/29/25, 12/30/25, 1/2/26, 1/3/26, 1/4/26, 1/5/26, 1/7/26, 1/8/26, 1/9/26, 1/10/26 and 1/13/26. Review of facility policy, Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy & Rehab, last reviewed 4/7/25, revealed in pertinent part, "1. If an employee receives an allegation of abuse, neglect, exploitation or misappropriation of resident/client property or witnesses suspected abuse, neglect or misappropriation of resident/client property, the employee will take measures to protect the resident/client, provided the safety of the employee is not jeopardized. The employee will then	F0600		

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F0600 SS = SQC-J	Continued from page 8 Disturbance and Anxiety Disorder. The MDS, with an ARD of 9/14/25, revealed the resident had sever cognition impairment with a BIMS score of 0 out of 15. The assessment further revealed R1 was dependent on staff for hygiene, dressing and mobility. Further review of R1's medical chart revealed R1 died in the facility on 10/24/25. Review of R1's Progress Note dated 9/22/25 at 5:09 PM by the DON revealed, "Resident was in commons room today in wc (wheelchair) with blanket on lap. Resident was approached by another male resident who had inappropriately rubbed breast, abdomen, and vaginal region. Immediately upon notification of event residents were separated and redirected. [R1's name] has a BIM of 0 and was not aware of situation or that she was touched when asked. [R1's name] will be monitored for any changes in baseline for any post effects of event x 3 days. Physician notified, DNS, Administrator, Social worker and MDS coordinator all notified." Review of R1's Skin Observation list revealed R1 had a skin assessment performed on 9/22/25 and then on 10/3/25. Review of R1's Progress Notes revealed on 9/22/25 at 5:30 PM, the SSD left a voicemail for R1's son to call back. Review of R1's Progress Note dated 9/23/25 at 1:57 PM revealed in pertinent part, "Assessed chest and lower abdomen. No bruising or redness. Scars from double mastectomy only. In good spirits, smiling, saying, "I love you." Review of R1's Progress Note dated 9/23/25 at 3:57 PM revealed in pertinent part that R1's son was notified of incident via email. Review of R1's Progress Note dated 9/26/25 at 9:39 AM revealed in pertinent part, "Resident continues at baseline. Skin nassessments [sic] have been WNL (within normal limits). BIMS is 0. No change in emotional status." Review of R2's Progress Note dated 9/22/25 at 5:16 PM by the DON revealed in pertinent part, "Resident was in commons room today in [sic] moving around independently in w/c. Resident approached another female resident sitting in her w/c in commons are [sic]. At this time, said resident advanced inappropriately rubbed breast, abdomen, and vaginal region."	F0600		

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F0600 SS = SQC-J	Continued from page 9 Review of R2's Progress Note dated 9/23/25 at 1:21 PM revealed, "Resident 15 minute check initiated on 9/22/25 r/t [related to] resident to resident incident with documentation on observation flow sheet. Evening of 9/22/25 resident observation increased to line of sight of staff when out of bed d/t [due to] increase in behaviors." Review of R2's 15 minute observation check sheets revealed R2 had 15 minute checks performed starting on 9/23/25 at12:00AM through 9/27/25 at 11:45 PM with the exception of when R2 was transferred to the ER on 9/23/25 at 2:45 PM through 9/23/25 at 7:00 PM. R2's chart lacked documentation that R2 had 15 minute checks completed from 9/22/25 when incident took place at 11:36 AM through 9/22/25 at 11:45 PM. Review of R2's Care Plan revealed in pertinent part, "inappropriate sexual statements and sexual touching: Attempt nonpharmacological interventions such as; redirection about appropriate behavior, having the bible read to him, and snacks." This was initiated on 9/22/25. Review of R2's fax communication to physician note dated 9/22/25 revealed that R2's physician was notified of the Resident to Resident sexual abuse. Review of R2's Progress Note dated 9/23/25 at 1:18 AM revealed in pertinent part, "This evening the resident was self propelling in his w/c with his pants and protective underwear partially down and was exposing himself to peers but staff would intervene and bring him to his room, move peers away from him and remind him to stay covered. He then was yelling at staff calling them assholes and fat. Peers would move away from him if able and he did take his HS meds and calmed some but then he would go down hallways and try go into the rooms (they were the first room on the right which his room in on his wing) this writer reminded him it was not his room and he said "You just think you fucking know everything"." Review of R2's Progress Note dated 9/23/25 at 8:00 AM revealed, "Resident was in dining room for breakfast and throughout breakfast he continued inappropriate behaviors and talk towards staff. At one point resident made a kissing face towards writer and writer kindly asked him not to do that as its inappropriate. He stated to table mate "gee they cant [sic] even take a joke but i [sic] wonder what they do when their husbands say things like that to them." A while later writer was at counter in dining room and resident	F0600		

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F0600 SS = SQC-J	Continued from page 10 slapped writers butt. Writer told resident this is highly inappropriate and he will need to leave the dining room with this kind of behavior." Review of R2's Progress Note dated 9/23/25 at 1:59 PM revealed, "Notified [Psychiatry Physician Assistant name] from [Psychiatry clinic name] regarding resident's behavior. Received orders to discontinue Abilify (antipsychotic medication) 5mg [milligrams] at hs [bedtime] and increase Trazodone (antidepressant) from 25mg to 50mg at hs." Review of R2's Progress Note dated 9/23/25 at 2:15 PM revealed, "Received call from [physician hospital name] to send resident to ER at [hospital name]." Review of R2's Psychiatry note dated 10/7/25 revealed in pertinent part, "[R2's name] did not tolerate Abilify trial as this made his hypersexual behaviors worse. Once this was discontinued, his Trazodone dose was increased and his PCP [primary care physician] started Risperidone (antipsychotic medication) 0.25 mg qHs [every night]. Review of message screenshot dated 9/23 at 3:07 PM revealed that a message was sent by the NHA to 67 staff recipients entailing, "If an observation or allegation of resident to resident abuse, including inappropriate touching, the residents will be separated immediately and both ensured a safe environment. Stay with resident if needed to ensure safety while notifying charge nurse. Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse, including "Sexual activity or fondling where one of the resident's capacity to consent to sexual activity is unknown" and including injuries of unknown origin will be reported immediately to the administrator or DNS." During an interview on 1/13/26 at 1:22 PM, R3 stated that she was sitting in the area when the resident to resident incident occurred. R3 said that R1 was "out of it" and it was unknown if R2 knew what he was doing. R3 said that R2 put his hand under R1's blanket and rubbed her stomach. R3 said she told staff but could not remember who she told. R3 said that she did not think it was fair because R1 did not know what was going on. R3 said that R2 was "off his rocker." R3 denied ever being scared of R2. During an interview on 1/13/26 at 2:50 PM, Food Services Assistant (FSA)1 said that R2 seemed to like to touch females. FSA1 said that R2 had smacked her butt before and she turned around and told him no. FSA1 denied any other concerns with abuse.	F0600		

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F0600 SS = SQC-J	Continued from page 11 During a telephone interview on 1/13/26 at 3:43 PM, LPN1 said that she was not involved in the resident to resident sexual abuse between R1 and R2 but they did a "Learning Center" training and after the incident the NHA had a meeting and said if they saw anything concerning they should report to the NHA and the DON and do an investigation. During an interview on 1/13/26 at 4:10 PM, the DON said that when the incident occurred between R1 and R2 it was witnesses that said R2 had touched R1. The DON said that when the DON looked, R2 was just sitting there. The DON said they looked at the video and it looked like R2 was trying to console R1 but staff reacted immediately. The DON said R1's BIMS was very low and she was unaware of her surroundings and situations. The DON said it was unknown if R1 did know anything about what was going on. During an interview on 1/13/26 at 4:28 PM, the NHA said that she was not a part of the incident between R2 and R1 but R2 touched R1's breast and she did an investigation and reported the incident to the state agency. The NHA said that R2 had seen psychiatry that day and she provided staff education through a notification system to notify immediately of all situations. The NHA said that abuse training is provided annually though [name of training center] for all staff and "as needed as things come up." During an interview on 1/14/26 at 3:19 PM, the NHA said that the resident to resident sexual abuse between R2 and R1 was not reported to the police because it was resident to resident and did not result in major injury. The NHA said that the facility always notifies police for misappropriation of property or for staff to resident abuse but not typically for resident to resident abuse that does not result in a major injury.	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the	F0609	1. For R2 –no longer resides in facility. The resident passed away on 1/9/2026. The Investigation team reviewed GS Abuse and Neglect Policy and the ND Memorandum Reporting protocol specific to reporting criteria on 1/14/26. 2. For all other residents having the potential to be affected by the same deficient practice. The facility investigation team will review allegations of abuse and neglect and follow reporting protocol per GS Abuse and Neglect Policy and ND Memorandum Reporting. 3. In-Service Training: Director of Nursing and Administrator provided education for all staff on	

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F0609 SS = D	Continued from page 12 allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to report a staff to resident abuse allegation for Resident (R)2 to the State Survey Agency as required. The Administrator (NHA) confirmed that she was aware of the abuse allegation. This failure puts all residents in the facility at risk for abuse. The facility reported a census of 42. Findings include: Review of R2's Care Plan revealed R2 was admitted to the facility on 6/3/25. Pertinent diagnoses included, Chronic heart failure, hypertension (high blood pressure), epilepsy (seizure disorder), traumatic subdural hemorrhage (bruise on the brain), generalized anxiety disorder, major depressive disorder, traumatic brain injury, unspecified psychosis, altered mental status and dementia . The Quarterly Minimum Data Set (MDS – federally mandated assessment), with an assessment reference date (ARD) of 11/13/25, revealed the resident had moderate cognition impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The assessment further revealed R2 was dependent on staff for rolling in bed and used a wheelchair. The assessment also revealed that R2 required maximum assistance with bed to chair transfers and transitioning from sitting to standing. Further review of R2's medical chart revealed that R2 died in the facility on 1/9/26. Review of R2's progress note dated 11/23/25 at 4:14 PM	F0609	Continued from page 12 1/14/26 to report to their immediate supervisor all allegations of abuse and neglect per GS Abuse and Neglect Policy. The GS RCSD provided education 1/14/26 to facility investigation team (Administrator, Director of Nursing and Social Services) to review all allegations of abuse, investigation and reporting protocols per GS Abuse and Neglect Policy and ND Memorandum Reporting. New Facility Practice: Facility investigation team will notify GS Rehab Clinical Services Director and/or GS Senior Director of allegations of abuse and neglect to verify reporting criteria. All allegations will be reviewed each business day to verify reporting criteria requirements are followed. Clinical Morning Meeting agenda updated to include review progress notes for each clinical meeting. 4. Audit: The DNS or designee will complete audits on all allegations of abuse and neglect were reviewed, investigated and reported to State Survey Agency as per GS Abuse and Neglect Policy and ND Memorandum Reporting protocol specific to the 2-hour requirements. Audits will be completed weekly x 4, monthly x 3 and quarterly x 1. All audit findings will be submitted to the Quality Committee for review and further recommendations 5. Completion date: 1/22/2026	

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F0609 SS = D	Continued from page 13 by LPN1 revealed, “Resident in chapel. Approached resident and resident stated " I don't want to be beat up anymore. Please don't let them. That black guy (NOC [night shift] CNA) he hit me on the head the other night and kept hitting me. And then he picked me up off the floor and threw me into bed." Resident began to cry. " He's always saying he's gonna pull my ears and then he does. " When asked if he felt safe resident replied "No." Asked if it was just the black guy or other staff and resident replied "just [CNA1 name] (black NOC CNA)." When asked if resident felt comfortable with [CNA1 name] providing cares, resident replied 'NO. please don't let him hurt me anymore." Reassured resident that nurse would pass on for [CNA1 name] not to be caretaker this evening. Message left for SS [SSD].” Review of R2’s progress note dated 11/23/25 at 4:35 PM by Registered Nurse (RN) 1 revealed, “Resident states that about 1 week ago a male caregiver wanted to put him to bed, but resident did't [sic] want to go to bed so the male caregiver threw him into bed. 2 caregivers are providing all cares for resident at this time.” During review of Facility Reported Incidents provided by the NHA on 1/13/26 at 1:15 PM, the NHA confirmed that the only incidents that were reported to the State Survey Agency during the time frame of September 2025 through present were 11/11/25, 9/22/25, and 12/21/25. During an interview on 1/13/26 at 2:47 PM, the SSD said that her role in any abuse investigation is that she helps with audits. The SSD said that anything reported comes from the Director of Nursing (DON) or NHA. During a telephone interview on 1/13/26 at 3:43 PM, LPN1 said that R2 had made comments to her that someone was mean to him. LPN1 said that R2 said a staff member was rough with him and would kind of push him around when they would turn him and that the staff member would pull on him. LPN1 said that R2 told her that the staff member that did this was CNA1. LPN1 said that there were multiple times that R2 would “get on this kick where he would say those things.” LPN1 said R2 told her about two to three times about these concerns around late October to early November and she reported these concerns to the DON, NHA, and SSD. LPN1 said that she left a voicemail for the SSD on her phone regarding the abuse allegation and notified the DON and NHA in person the next day she worked which was either Monday or Tuesday. During an interview on 1/13/26 at 4:28 PM, the NHA said that there were no staff to resident abuse allegations	F0609		

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F0609 SS = D	Continued from page 14 that she was aware of. The NHA said that if a staff to resident abuse allegation arose, staff should tell the NHA or the DON immediately. The NHA said that there were comments made of a staff member hurting R2 but R2 would also want CNA1 to help him. The NHA said she did not document anything, she “is not nursing and she is not good about documenting that, but she probably should.” The NHA said that this would be an incident that they would investigate and said it is unknown to her if CNA1 worked after this incident and she would need to find out. During an interview on 1/14/26 at 8:41 AM, the NHA said that the abuse allegation had come up Friday 11/21/25 initially and was reported to the NHA on Monday 11/24/25. The NHA said that LPN1 is a newer nurse so she may not have recognized this as potential abuse. During a telephone interview on 1/14/26 at 1:01 PM, CNA1 said that he helped R2 once in a awhile. CNA1 said that no one had accused him before of being rough with any patient. CNA1 said that he was never suspended from caring for residents at the facility. During an interview on 1/14/26 at 2:25 PM, the Regional Clinical Services Director (RCSD) said that the abuse allegation had not been reported to the State Agency. The RCSD said she was unsure if this should be reported or not now because it had happened so long ago. During an interview on 1/14/26 at 5:44 PM, the DON said abuse is any allegation from a resident whether they have been injured or sexual abuse. The DON said staff should report any concern immediately. The DON said that she would make sure the resident is safe and suspend the staff member if it was an allegation for staff to resident abuse. The DON said she would also report to the state agency as well. The DON said that harm to a resident could happen if something was not investigated thoroughly. During an interview on 1/14/26 at 6:37 PM, the NHA said if a staff member told her of an abuse concern, she would ask the details and if it was a staff to resident abuse allegation, she would immediately suspend the staff member and start the investigation. The NHA said she has 2 hours to report the allegation to the state agency. The NHA said that the police were not notified for the staff to resident abuse allegation. Review of facility policy, Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy & Rehab, last reviewed 4/7/25, revealed in pertinent part,	F0609		

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F0609 SS = D	Continued from page 15 "c. Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency. If applicable, Adult Protective Services will be notified where state law provides for jurisdiction in long-term care centers.If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident/client property, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made.If there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported not later than 24 hours after the allegation is made."The policy further revealed, "10. The social worker or designated employee will report the results of all investigations to the state survey and certification agency and other officials within five working days of the event, unless otherwise specified by state law, whichever is stricter."	F0609		
F0610 SS = SQC-J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to complete a thorough investigation when Resident (R)2 told Licensed Practical Nurse (LPN)1 that	F0610	1.For R2 – passed away on 1/9/26. The Facility Investigation team (Administrator, Director of Nursing and Social Services) reviewed the ND Memorandum for Reporting 1/14/26. 2. For all other residents having the potential to be affected by the same deficient practice, the facility must ensure residents are free from abuse and neglect. The facility investigation team will review, investigate, and report allegations of Staff to Resident abuse per GS Abuse and Neglect Policy and ND Memorandum Reporting protocol. 3. In-Service Training: Administrator LC provided education for all staff on 1/14/26 on GS Abuse and Neglect Policy review, investigation and specifically reporting allegations of abuse and neglect to immediate supervisor. The facility investigation team (Administrator, Director of Nursing and Social Servies) educated on GS Abuse and Neglect Policy for all allegations of abuse and neglect to be reviewed, investigated and reported per GS Abuse and Neglect Policy and ND Memorandum Reporting protocols. New Facility Practice- Facility investigation team will notify GS Rehab Clinical Services Director and /or GS Senior Director of all allegations of abuse and neglect to verify investigation and reporting criteria. Facility will utilize the Good Samaritan How to investigate alleged resident abuse and neglect booklet for all alleged abuse and neglect allegations.	

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F0610 SS = SQC-J	Continued from page 16 Certified Nursing Assistant (CNA)1 hit him on the head, pulled his ears and threw him onto the bed. This failure has the potential to affect all residents in the facility. The facility reported a census of 42. The Administrator (NHA) was notified of the Immediate Jeopardy (IJ) on 1/14/26 at 9:15 AM. The facility submitted an acceptable IJ Removal Plan on 1/14/26 at 3:09 PM. The Regional Office (RO) Surveyor was able to verify implementation of the removal plan and remove the immediacy on 1/14/26 at 7:31 PM. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "D". Removal Plan: “Resident (2) no longer resides in the 1/14/26 facility. Facility investigative team with [corporation name] regional support will review and finalize investigation for resident (2) CNA (1).” “CNA (1) suspended until investigation complete. Facility investigative team: administrator, DNS [Director of Nursing Services] and Social Services Designee [SSD] received education by [corporation initials] Regional support consultant team on [corporation initials] Abuse and Neglect Policy and Procedure specific to immediate, thorough investigation with documentation. To prevent further deficient practice, the IDT [intradisciplinary team] team will review progress notes daily to initiate immediate investigation of concerns if indicated and the regional clinical services director or designated regional support leader will meet with administrator DNS, and Social Services Designee weekly via web ex or in person and as needed to review in progress investigations and provide feedback on improving thoroughness of investigations.” “Abuse and Neglect Policy and Procedure reviewed. No policy changes” “Education to administrator, DNS, and Social Services Designee by Regional Clinical Services Director [RCSD] on new system process noted above.” Findings include: Review of R2’s Care Plan revealed R2 was admitted to the facility on 6/3/25. Pertinent diagnoses included,	F0610	Continued from page 16 4. Audit: The DNS or designee will complete audits on all allegations of abuse and neglect were reviewed, investigated and reported to State Survey Agency as per GS Abuse and Neglect Policy and ND Memorandum Reporting protocol specific to the 2-hour requirements. Audits will be completed weekly x 4, monthly x 3 and quarterly x 1. All audit findings will be submitted to the Quality Committee for review and further recommendations 5. Completion date: 1/22/2026	

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F0610 SS = SQC-J	Continued from page 17 Chronic heart failure, hypertension (high blood pressure), epilepsy (seizure disorder), traumatic subdural hemorrhage (bruise on the brain), generalized anxiety disorder, major depressive disorder, traumatic brain injury, unspecified psychosis, altered mental status and dementia . The Quarterly Minimum Data Set (MDS – federally mandated assessment), with an assessment reference date (ARD) of 11/13/25, revealed the resident had moderate cognition impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The assessment further revealed R2 was dependent on staff for rolling in bed and used a wheelchair. The assessment also revealed that R2 required maximum assistance with bed to chair transfers and transitioning from sitting to standing. Further review of R2's chart revealed that R2 died in the facility on 1/9/26. Review of R2's progress note dated 11/23/25 at 4:14 PM by LPN1 revealed, "Resident in chapel. Approached resident and resident stated " I don't want to be beat up anymore. Please don't let them. That black guy (NOC [night shift] CNA) he hit me on the head the other night and kept hitting me. And then he picked me up off the floor and threw me into bed." Resident began to cry. " He's always saying he's gonna pull my ears and then he does. " When asked if he felt safe resident replied "No." Asked if it was just the black guy or other staff and resident replied "just [CNA1 name] (black NOC CNA)." When asked if resident felt comfortable with [CNA1 name] providing cares, resident replied 'NO. please don't let him hurt me anymore." Reassured resident that nurse would pass on for [CNA1 name] not to be caretaker this evening. Message left for SS [SSD]." Review of R2's progress note dated 11/23/25 at 4:35 PM by Registered Nurse (RN) 1 revealed, "Resident states that about 1 week ago a male caregiver wanted to put him to bed, but resident did't [sic] want to go to bed so the male caregiver threw him into bed. 2 caregivers are providing all cares for resident at this time." During an interview on 1/13/26 at 2:47 PM, the SSD stated if a someone came to her regarding abuse she would report to the "higher ups" and assist in the investigation. The SSD stated that there was no staff to resident abuse allegations that she was aware of. During a telephone interview on 1/13/26 at 3:43 PM, LPN1 said that R2 had made comments to her that someone was mean to him. LPN1 said that R2 said a staff member was rough with him and would kind of push him around	F0610		

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F0610 SS = SQC-J	Continued from page 18 when they would turn him and that the staff member would pull on him. LPN1 said that R2 told her that the staff member that did this was CNA1. LPN1 said that there were multiple times that R2 would “get on this kick where he would say those things.” LPN1 said R2 told her about two to three times about these concerns around late October to early November and she reported these to the Director of Nursing (DON), NHA, and SSD about the comments. LPN1 said that she left a voicemail for the SSD on her phone regarding the abuse allegation and notified the DON and NHA in person the next day she worked which was either Monday or Tuesday. LPN1 said she should have notified them immediately about the abuse concerns. During an interview on 1/13/26 at 4:17 PM, RN1 said that the progress note on 11/23/25 regarding R2 saying that a male caregiver threw him into bed and he was on two person cares (2 staff members providing care to resident) was maybe because there were some accusations made. RN1 said that because two person cares were already implemented, she thought the allegations had already been reported. During an interview on 1/13/26 at 4:28 PM, the NHA said there were no staff to resident abuse allegations that she was aware of. The NHA said that if a staff to resident abuse allegation did come up, staff should tell the NHA or the DON immediately. When the surveyor asked the NHA about R2 and the abuse concerns he brought up to LPN1 and RN1, the NHA said that there were comments made by R2 of a a staff member hurting him but R2 would also want CNA1 to help him. The NHA said that when she spoke to R2 regarding CNA1 that R2 said he liked him and could not give her examples regarding concerns of CNA1. The NHA1 said that she did not document anything as she is “not nursing and she is not good about documenting but she probably should.” The NHA said she cannot find where the two person cares are documented in R2’s care plan. The NHA said that when R2 made the statements to the staff member, she would expect that “they” would eliminate CNA1 from his cares to ensure his safety. RO Surveyor requested all grievances and incident reports from the facility on 1/13/26 that were reported from September 2025 through present. NHA provided RO Surveyor with requested items on 1/13/26. Review of facility grievances and reported incidents provided to surveyor from September 2025 through present lacked any documentation of staff to resident abuse allegation from 11/23/25. During an interview on 1/14/26 at 8:41 AM, the NHA	F0610		

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F0610 SS = SQC-J	Continued from page 19 provided the surveyor a grievance form that was not provided with grievance documents from the previous day. The NHA said that R2 was moved to an assist of two staff members on Saturday 11/22/25 before R2 reported the incident to LPN1 and RN1. The NHA said that the SSD was trying to interview R2 but R2's sodium was low. The NHA said that R2 would make different allegations in the evening versus day times and he was quick to sexualize nurses. The NHA said that LPN1 did not follow the right process and she had spoken with her. The NHA said that the initial abuse allegation concern had come up Friday and then came to leadership on Monday. The NHA said that LPN1 was a newer nurse and that she may not have recognized potential abuse because it was different than Resident to Resident abuse. Review of document titled, Suggestion or Concern, last reviewed 11/13 dated 11/23/25 revealed in part, "Resident [R2's name] verbalized concern [with] Black NOC [night shift] CNA (CNA1's name) Has been making accusation about cares since Friday evening and was put on assist of two. Will cont (continue) 2 assist and monitor" The document further revealed this was reported by LPN1 and written by the DON. Under the Investigation section of the Suggestion or Concern document the following was documented. "Visited [with] [CNA1's name], he stated provided cares of assist of [two] always because of behaviors. Attempted to interview [R2's initials] x 2- See prog (progress) note. Interviewed 5 residents- see audit sheet." This section was signed by the DON and the SSD and dated 11/24/25. The Resolution section of the document revealed, "Continue with 2 staff for personal cares in private/residents room at all times. Verbal education to staff for Documentation & leadership notification of Resident concerns." This section was signed by the DON and dated 11/26/25. Review of R2's Progress Note dated 11/24/25 at 1:51 PM by the SSD revealed, "Writer attempted to interview resident on weekend report, unable to wake resident up and question. Will continue to follow up." Review of R2's Progress Note dated 11/25/25 at 5:18 PM by the SSD revealed, "Writer discussed with resident previous concerns brought forward. Listen and validated concerns. Will continue with care plan of assist of 2 for resident and staff safety." Review of R2's Care Plan revealed R2 requires assist of two for dressing and undressing and with bathing. This care plan area was dated that it was initiated on 1/13/26 which was four days after R2 died.	F0610		

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F0610 SS = SQC-J	Continued from page 20 Review of R2's Skin Observation Log revealed that R2 did not have a skin assessment performed from 9/20/25 through 12/14/25. Review of R2's medical chart lacked any documentation that R2's family or medical provider were notified of abuse allegation. During a telephone interview on 1/14/26 at 1:01 PM, CNA1 said that he helped R2 once in a awhile. CNA1 said that no one had accused him before of being rough with any patient. CNA1 said that he was never suspended from caring for residents at the facility. During an interview on 1/14/26 at 3:15 PM, the RCSD said that R2 did not have a skin or trauma assessment completed after the incident on 11/23/25. Review of the facility's nursing schedule of days worked revealed in pertinent part that CNA1 worked on the following dates during the evenings and nights: 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/26/25, 11/27/25, 11/28/25, 11/29/25, 11/30/25, 12/1/25, 12/2/25, 12/3/25, 12/5/25, 12/6/25, 12/7/25, 12/8/25, 12/11/25, 12/12/25, 12/13/25, 12/14/25, 12/15/25, 12/16/25, 12/17/25, 12/18/25, 12/19/25, 12/20/25, 12/21/25, 12/22/25, 12/24/25, 12/25/25, 12/26/25, 12/27/25, 12/28/25, 12/29/25, 12/30/25, 1/2/26, 1/3/26, 1/4/26, 1/5/26, 1/7/26, 1/8/26, 1/9/26, 1/10/26 and 1/13/26. Review of R2's medical chart revealed there was not a SAFE (Safety Awareness Facts & Education) Report documented for this event. Review of facility policy, Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy & Rehab, last reviewed 4/7/25, revealed in pertinent part, "1. If an employee receives an allegation of abuse, neglect, exploitation or misappropriation of resident/client property or witnesses suspected abuse, neglect or misappropriation of resident/client property, the employee will take measures to protect the resident/client, provided the safety of the employee is not jeopardized. The employee will then report the allegation to a supervisor. 2. The program coordinator, charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin,	F0610		

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F0610 SS = SQC-J	Continued from page 21 he or she also will attempt to determine the cause of the injury. The coordinator or charge nurse also will ensure that any potential for further abuse is eliminated by taking one of the following actions:If this is an allegation of employee to resident/client abuse, the employee will be removed from providing direct care to all residents/clients. Additionally, the employee will be placed on suspension pending the results of the internal investigation. Another employee will be assigned to complete the care of the resident/client."The policy further revealed, "3. A designated individual will enter the event into the SAFE Event Reporting Portal per the Event Reporting Resident, Visitor, Employee policy. 4. Notification procedures: a. Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator. b. In case of absence of the administrator, follow the chain of command for notification (director of nursing services, social worker, etc.). If the alleged perpetrator is one's supervisor or department manager, notify his or her supervisor. Document this notification into the SAFE Event Reporting Portal per the Event Reporting Resident, Visitor, Employee policy."	F0610		