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	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Park River	301 South County Road 12b Park River, ND 58270

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40488 40489 Based on observation, review of facility grievances, review of the North Dakota Long Term Care Ombudsman Program's Guide to Resident Rights, and staff interview, the facility failed to treat residents with respect and dignity and failed to provide resident care in a manner and an environment that promotes, maintains, or enhances their quality of life on 1 of 1 days of survey. Failure to treat residents with dignity and speak respectfully has the potential to affect the residents' psychosocial wellbeing. Findings include: The North Dakota Long Term Care Ombudsman Program's Guide to Resident Rights, updated 03/21/23, stated, . The facility must treat you courteously, fairly and with dignity. Observation on 03/12/24 at 8:05 a.m. showed three unidentified certified nurse aides (CNAs) and three unidentified residents sitting at a table in the dining room. The three staff members conversed amongst themselves and failed to interact with the three residents. At 8:15 a.m., one of the three unidentified CNAs started to pound two fingers loudly on the table and stated, [Resident's first name]. [Resident's first name]. Hey you better wake up and eat. Another unidentified resident at a different table with the same first name stated, I am eating. The unidentified CNA stated, No not you [Resident's first and last] but this [Resident's first name] at this table. Review of facility grievances filed in the last 6 months included: * On 10/04/23, Resident didn't feel attitude of facility staff were encouraging to him. * On 12/01/23, Facility staff not approachable. * On 12/20/23, Resident stated when he/she puts the call light on, the facility staff come in and say in an unpleasant tone, What do you want? The resident stated on a grievance he/she does not feel like he/she should be treated like this. During an interview on 03/12/24 at 4:50 p.m., an administrative nurse (#1) stated she expected staff to treat all residents with respect and dignity.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 40488 Based on observation, review of facility policy, and staff interview, the facility failed to provide reasonable accommodation of needs regarding call lights for 1 of 1 sampled resident (Resident #2) observed during cares. Failure to ensure residents can reach/access the call light may result in unmet needs and the inability to call for help. Findings included: Review of the facility policy titled Call Light occurred on 03/12/24. This policy, dated 08/01/23, stated, . When leaving the room, place call light within easy reach of resident. Observations on 03/12/24 in Resident #2's room showed the following: * At 8:42 a.m., a certified nurse aide (CNA) (#2) completed cares, assisted the resident into his/her recliner, exited the room, and failed to place the call light within the resident's reach. * At 9:03 a.m., asleep in the recliner and the call light out of reach. * At 9:20 a.m., remained in the recliner with the call light out of reach. During an interview on 03/12/23 at 4:15 p.m., an administrative staff member (#1) stated she expected staff to ensure all residents' call lights are within their reach prior to exiting the resident's room. 40489

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 40489 Based on review of facility grievances, review of facility policy, resident interview, and staff interviews, the facility failed to implement an effective grievance system for 1 of 1 sampled resident (Resident #3) with a grievance regarding missing items. Failure to act upon resident and/or their representatives' grievances may result in continued resident dissatisfaction. Findings included: Review of the facility policy titled Grievances, Suggestions or Concerns occurred on 03/12/24. This policy, dated November 2023, stated, . PURPOSE To document concerns, investigate findings and plans of corrections. To develop a systemic approach in resolving grievances as a tool to ensure continuous quality of care . The grievance will be documented . The grievance official will issue a written grievance decision to the individuals filing the concern and to the administrator. The written grievance decision must include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken by the facility as a result of the grievance, and the date the written decision was issued. During an interview on 03/12/24 at 2:15 p.m., Resident #3 stated he/she was missing a jacket and had reported it missing about a month ago and I haven't heard anything about it since then. During an interview on 03/12/24 at 4:40 p.m., an administrative staff member (#6) confirmed Resident #3 had informed her of the missing jacket about a month ago and she failed to complete a missing item report, investigate the grievance, and follow up with the resident. The facility failed to ensure Resident #3's right to file a grievance included documentation, investigation, and follow up with the resident and/or their representative regarding the missing item.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40488 Based on record review, review of facility policy, and resident interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 2 of 4 sampled residents (Residents #1 and #2). Failure to review and revise care plans limits staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled Comprehensive Care Plan And Care Conferences occurred on 03/12/24. This policy, dated 12/04/23, stated, PURPOSE To develop a person-centered care plan for each resident that includes measurable objectives and timetables to meet his or her physical, mental, spiritual and psychological wellbeing. To provide an ongoing method of assessing, implementing, evaluating and updating the resident's care plan to help maintain the resident's highest practicable level of function . - Review of Resident #1's medical record occurred on all days of survey. The resident's care plan stated, . SUPPORT STOCKINGS: Apply and/or remove single layer tubigrip to bilateral lower extremities on AM [morning], off HS [bedtime]. During an interview on 03/12/24 at 2:30 p.m., Resident #1 reported she no longer wears the tubigrips. The resident stated, They cut off my circulation and I didn't like them. The facility failed to update Resident #1's care plan to reflect refusal to wear and/or remove use of the tubigrips. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included unspecified stage ulcers to the left and right heels and repeated falls. A provider order, dated 02/12/24, stated, . [right] heel protector - wear boots cont'ly [continuously] unless walking. L [left] heel . heel protector . wear cushioning boots cont'ly unless walking . Nursing progress notes dated February 16, 17, 20, 23, 26 and 28, 2024 indicated a bed and chair alarm used for Resident #2's safety. Resident #2's care plan lacked use of cushioned boots and bed and chair alarms. 40489

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 40488 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide care and services to promote the healing or prevent the development of pressure ulcers for 1 of 2 sampled residents (Resident #2) with current pressure ulcers. Failure to consistently apply pressure relieving devices as ordered may result in the deterioration of new/existing pressure ulcers and delayed healing. Findings include: Review of the facility policy titled Pressure Ulcer Treatment and Intervention Guidelines occurred on 03/12/24. This policy, dated 02/01/24, stated, . Consider Wound Care Guidelines for routine skin care and when initiating treatment for residents with wounds. Elevate heels off bed as indicated (e.g. utilize foam heel lift boots .). Review of Resident 2's medical record occurred on 03/12/24. Diagnoses included unspecified stage ulcers to the left and right heels. A nursing progress note, dated 02/12/24 at 2:32 p.m., stated, . Resident returned from clinic appt [appointment] with [the] following orders . Wear cushioning boots continually unless walking. A provider order written on a Clinic Referral Form, dated 02/12/24, stated, . [right] heel protector - wear boots cont'ly [continuously] unless walking. L [left] heel . heel protector . wear cushioning boots cont'ly unless walking . Resident #2's Medication Administration Record (MAR), Treatment Administration Record (TAR), and care plan lacked an order and/or intervention for use of cushioned heel boots. Observations of Resident #2 on 03/12/24 showed the following: * At 8:20 a.m., self-propelled in a wheelchair with no cushioned boots in place. * At 8:42 a.m., resting in the recliner in his/her room with no cushioned boots in place. * At 9:05 a.m., remained sleeping in the recliner with no cushioned boots in place. * At 9:30 a.m., a licensed nurse (#2) changed the dressings to the resident's bilateral heels and instructed a certified nurse aide (CNA) (#3) to place the cushioned boots onto the resident's feet and stated, [He/She is supposed to have them [the cushioned boots] on at all times. The CNA (#3) responded, I didn't know that and then placed both boots on the resident's feet. * At 11:12 a.m., the CNA (#3) removed the cushioned boots, assisted the resident to a standing position, and transferred the resident into the wheelchair. The CNA failed to place the cushioned boots back on the resident's feet and wheeled the resident to the dining room for lunch. * At 1:15 p.m., sleeping in the recliner in his/her room with no cushioned boots in place. * At 1:38 p.m., the nurse (#2) reminded the CNA (#3) to apply the cushioned boots to the resident's feet. The CNA then applied the cushioned boots to the resident's feet. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 03/12/24 at 2:56 p.m. and at 3:00 p.m., when asked how the CNAs know what type of assistance and cares are required for their assigned residents, a CNA (#5) stated, It's on the charting screen and a CNA (#4) stated, I communicate with other staff persons [I'm] working with and also most of the residents are alert enough to tell us. 40489

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40488 40489 Based on observation, record review, review of facility policy, and staff interview, the facility failed to use an assistive device necessary to safely transfer a resident and ensure the chair alarm is in place to prevent accidents for 1 of 1 sampled resident (Resident #2) observed during a transfer. Failure to use a gait belt, lock the wheelchair brakes during the transfer, and place the chair alarm may result in falls and/or injuries to the resident. Findings include: Review of the facility policy titled Fall Prevention occurred on 03/12/24. This policy, dated March 2023, stated, . PURPOSE To promote resident well-being . After a fall, a resident may experience lifestyle changes due to impaired function, decreased mobility and lost independence. It is our obligation to provide the safest environment possible for the residents trusted to our care. Review of the facility policy titled Gait-Transfer Belt occurred on 03/12/24. This policy, dated April 2023, stated, . PURPOSE To safely stabilize a transfer . To aid the residents in maintaining balance . Review of Resident #2's medical record occurred on 03/12/24. The care plan stated, . The resident has had an actual fall with minor injury R/T [related to] abnormalities of gait and mobility, anxiety E/B [evidenced by] falls, weakness, and impulsiveness. Assist of 1 [staff] to toilet and change product . A progress note, dated 02/26/24 at 2:05 p.m., stated, . Resident uses [sic] call light to notify staff that he fell . It is evident with blood spots at spaces in his room. His chair alarm is on the floor next to his recliner. Observation on 03/12/24 at 8:32 a.m., showed a certified nurse aide (CNA) (#3) assisted Resident #2 from the wheelchair to a standing position by lifting under the resident's left arm. During incontinent cares, the resident needed to sit down in the wheelchair twice. The CNA failed to lock the wheelchair brakes, and as the resident sat down, the wheelchair rolled back. Upon completion of the incontinent cares, the CNA transferred the resident into the recliner. The chair alarm pad lay on the floor beside the resident's recliner. At 8:42 a.m., the CNA exited the room and failed to place the chair alarm pad. The CNA also failed to use a gait belt and lock the wheelchair brakes while providing cares and transferring the resident. Observation on 03/12/24 at 11:12 a.m. showed a CNA (#3) assisted Resident #2 from the recliner to a standing position by lifting under the resident's right arm twice during check and change incontinent cares. During an interview on 03/12/24 at 4:44 p.m., an administrative nurse (#1) stated she expected staff to lock resident wheelchairs during transfers and use a gait belt and place chair alarm pads if indicated.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 40489 Based on record review, review of professional reference, and staff interview the facility failed to provide appropriate toileting/check and change cares for 1 of 4 sampled residents (Resident #2) who required staff assistance with toileting. Failure to provide toileting/check and change cares as care planned may result in a loss of dignity and placed the resident at risk for skin breakdown and urinary tract infections (UTIs). Findings include: Kozier & Erb's Fundamentals of Nursing: Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 892, stated, Fecal and Urinary Incontinence: Moisture from incontinence promotes skin maceration (tissue softened by prolonged wetting or soaking) and makes the epidermis more easily eroded and susceptible to injury. Digestive enzymes in feces, urea in urine . also contribute to skin excoriation (area of loss of the superficial layers of the skin .). Any accumulation of secretions . is irritating to the skin, harbors microorganisms, and makes an individual prone to skin breakdown and infection. Page 1221 stated, Managing Urinary Incontinence . Habit training, also referred to as timed or prompted voiding and scheduled toileting, attempts to keep clients dry by having them void at regular intervals, such as every 2 to 4 hours. The goal is to keep the client dry . Review of Resident #2's medical record occurred on 03/12/24 and included diagnoses of dementia, weakness, abnormalities of gait and mobility and repeated falls. The care plan stated, . The resident has episodes of bowel and bladder incontinence . Check/remind to toilet every 2-3 hours and prn [as needed] during the day. Allow to sleep undisturbed at least 4 hours at night. A physician order, dated 02/12/24, stated, Mepilex Dressing to coccyx. Change daily. Check prn [as needed] to avoid stool underneath dressing. every day shift for Skin breakdown coccyx related to PRESSURE ULCER OF LEFT BUTTOCK, STAGE 3 . Review of Resident #2's toileting record, dated February 12, 2024-March 12, 2024, identified 43 occasions where staff failed to check and change the resident as care planned. The record showed gaps of approximately 4 hours to 12 hours between the check and changes. During an interview on 03/12/24 at 5:00 pm. an administrative staff member (#1) stated she expected staff to provide toileting/check and change cares to all residents per their care plan.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40488 Based on observation, review of facility policy, review of facility call light logs, resident interviews, and staff interview, the facility failed to promptly respond to residents' call lights for 4 of 4 confidential residents (Residents A, B, C, and D) who required staff assistance. Failure to promptly respond to resident calls for assistance may result in residents experiencing unmet needs and may negatively affect the residents' physical, mental, and psychosocial well-being. Findings include: Review of the facility policy titled Call Light occurred on 03/12/24. This policy, dated 08/01/23, stated, . 2. When resident's call light is observed/heard, go to the resident's room promptly. 3. Respond to request as soon as possible. Turn call light off and inquire about resident's request. Observations on 03/12/24 at 2:39 p.m. showed Resident C activated the call light and stated to the surveyor he/she needed to be changed. At 2:56 p.m., a certified nurse aide (CNA) (#5) entered the resident's room, inquired about the resident's needs, and stated she would return shortly. At 3:00 p.m., the CNA (#5) and an unidentified CNA returned to the resident's room and began to assist the resident with toileting needs (21 minutes after the call light initially activated). During an interview on 03/12/24 at 2:35 p.m., when asked about sufficient staff/response to call lights, Resident A stated, It depends on who is working for call lights to be answered. I have waited 30 minutes or a little longer. Review of the facility call light logs from 02/01/24 through 02/03/24 identified length of time between resident call light activated and deactivated for the following: * On 02/01/24, Resident B = 34 minutes. * On 02/02/24, Resident B = 27 minutes. * On 02/02/24, Resident C = 54 minutes. * On 02/03/24, Resident D = 74 minutes. During an interview on 03/12/24 at 4:15 p.m., an administrative staff member (#1) indicated staff should answer call lights within ten minutes. 40489

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40488 Based on observation, review of professional reference, and staff interview, the facility failed to follow standards of infection control for 1 of 4 sampled residents (Resident #2) observed during incontinence cares. Failure to follow infection control standards has the potential to spread infections to residents, staff, and visitors. Findings include: Kozier & Erb's Fundamentals of Nursing: Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 678, stated, Table 31.5 Nursing Interventions That Break the Chain of Infection. Interventions: Ensure that articles are correctly cleaned and disinfected or sterilized before use. Rationales: Correct cleaning, disinfecting, and sterilizing reduce or eliminate microorganisms . reduces the likelihood of transmission. Intervention . Dispose of feces . in appropriate receptacles. Rationale . feces may contain many microorganisms. Observation on 03/12/24 at 8:32 a.m., showed Resident #2 seated in a wheelchair wearing a nasal cannula attached to an oxygen concentrator. A certified nurse aide (CNA) (#3) assisted the resident to a standing position from the wheelchair and provided incontinence cares while standing. During the incontinence cares, the resident's oxygen tubing and the outside of the clean brief came in contact with feces present on a disposable pad located on the wheelchair seat. Without applying a clean brief, the CNA (#3) pulled up the resident's pants and transferred him into the recliner. The CNA (#3) then used a skin cleansing wipe, not a disinfectant wipe, to wipe the feces off the resident's oxygen tubing. The CNA (#3) failed to place a clean brief on Resident #2 and disinfect or replace oxygen tubing after contact with the feces. During an interview on 03/12/24 at 4:50 p.m., an administrative staff member (#1) stated she expected staff to change an incontinence product soiled with feces and disinfect the portion of the oxygen tubing contaminated with feces or replace the tubing. 40489