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	12/04/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility reported incident (FRI) and investigation, review of facility policy, and staff interview, the facility failed to ensure residents remained free from abuse for 1 of 1 sampled resident (Resident #2) who displayed sexually inappropriate behaviors towards other residents. Failure to protect residents from sexual abuse placed all residents at risk for psychosocial harm and mental and emotional distress. inappropriate behaviors resulted in sexual abuse. Findings include:The surveyors determined a deficient practice existed on 09/22/25. The facility implemented and completed corrective action on 09/25/25. Review of the facility policy titled Abuse and Neglect . occurred on 12/04/25. This policy, revised 04/07/25, stated, . The resident/client has the right to be free from abuse. resident/client must not be subjected to abuse by anyone, including, but not limited to. other residents/clients.Review of the facility policy titled Abuse Definitions . occurred on 12/04/25. This policy revised 01/02/25, stated, . sexual abuse: non-consensual sexual contact of any type with a resident. Sexual abuse includes but is not limited to: 1. Unwanted intimate touching of any kind, especially of breasts and perineal area.Review of Resident #2's medical record occurred on 11/24/25. Diagnoses included dementia with other behavioral disturbance. The quarterly Minimum Data Set (MDS), dated [DATE], identified inappropriate sexual statements and sexual touching.The FRI, dated 09/22/25, stated, . resident [Resident #1] was approached by male resident [Resident #2] via w/c [wheelchair] along [Resident #1's] left side in commons area. [Resident #1] also in a wheelchair and was fidgeting with the blanket on her lap. Male resident attempted on first contact to assist with adjusting blanket. Male resident reached over to [Resident #1] where he made contact to blanket and lifted it and then lifted [Resident #1] shirt and rubbed breast abdomen region. Staff intervened and separated resident [sic]. Resident [Resident #1's] BIMS [brief interview of mental status (a cognitive screening tool)] 00 unaware of incident. There is no change from baseline.Progress notes identified the following:* 09/22/25 at 5:10 p.m., 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. Female resident has BIMS of 0 and was not aware of what was happening. Immediately upon notification of event residents were separated and redirected. Female resident was not aware of situation when asked and had no response. Female resident . will be monitored for any changes in baseline for any post effects of event x [times] 3 days. Physician notified, DNS [Director of Nursing Services], Administrator, Social worker and MDS coordinator all notified.* 09/23/25 at 1:18 a.m., 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.* 09/23/25 at 1:21 p.m., Care Plan Change . Resident 15 minute check [sic] initiated on 09/22/25 r/t [related to] resident to resident incident with documentation on observation flow sheet. Evening of 9/22/25 resident observation increased to in line of sight of staff when out of bed d/t [due to] increase in behaviors.* 09/23/2025 2:12 p.m., Contacted [hospital] regarding situation with resident. [Psychiatrists'] office verbal instructions to discontinue abilify (an antipsychotic medication) and increase trazadone (an antidepressant medication) to 50 mg [milligrams]. He also instructs to send to [hospital] for psyc [sic] [psychological] eval [evaluation]. Spoke with clinic nurse and she will call back with direction for action.* 09/23/2025 2:15 p.m., Received call from [hospital] to send resident to ER [emergency room] .* 09/23/2025 2:23 p.m., Resident left facility for a psych eval in ER .During an interview on 11/24/25 at 2:30 p.m., an administrative nurse [#1] reported Resident #1 had no injury or recall of the incident and has since passed away. She also confirmed there have been no other touching episodes in the facility since this incident occurred.Based on the following information, non-compliance at F0600 is considered past non-compliance. The facility implemented corrective actions for residents who may be affected by the deficient practice as follows:* Completed an investigation of the incident that occurred on 09/22/25 involving Resident #1 and Resident #2,* Provided staff education regarding sexual abuse and ensuring resident safety,* Educated staff to separate the residents, to stay with Resident #1, and report the incident to administration,* Directed staff to check on Resident #2 every 15-minutes, increasing to line-of-sight when out of bed, and record his behaviors per shift,* Ensured Resident #2 received a psychiatric evaluation in a timely manner,* Adjust Resident #2's medications per physician order,* Implemented audits to ensure resident safety, monitoring incident involving resident-to-resident sexual abuse