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	07/11/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46963 Based on record review and review of facility policy, the facility failed to follow physician's orders for 1 of 3 sampled residents (Resident #17) and 1 closed record (Resident #86) reviewed who experienced high and/or low blood sugars. Failure to notify the physician of blood sugar results above and/or below the ordered parameters may result in complications to the resident and prevent the physician from evaluating the need to alter treatment. Findings include: Review of the facility policy titled Blood Glucose Monitoring, Disinfecting and Cleaning occurred on 07/11/24. This policy, dated 01/31/24, stated, . If the medical provider has identified a low and high blood sugar for a resident . when the blood sugar varies from the baseline entered. the nurse will notify physician if necessary, per parameters. - Review of Resident #17's medical record occurred on all days of survey. Diagnoses included type two diabetes mellitus. Medications included, Insulin Aspart Injection Solution 100 UNIT/ML [milliliter] . related to TYPE 2 DIABETES MELLITUS WITH UNSPECIFIED COMPLICATIONS . For BS [blood sugar] > [greater than] 451 call MD [medical doctor]. Review of the January-July 2024 blood sugars log showed the following: * 01/03/24 - 453 mg/dL (milligrams per deciliter) * 01/07/24 - 458 mg/dL Review of the medical record showed the facility failed to notify Resident #17's physician of the blood sugar readings greater than 451. - Review of Resident #86's medical record occurred on all days of survey. Diagnoses included type two diabetes mellitus with hypoglycemia (low blood sugars) and insulin use. Medications included 10 milligrams (mg) Glipizide extended release one time a day, 20 units Humalog (short-acting insulin) two times a day (start date 03/29/24), 25 units Humalog one time a day (start date 03/30/24), 80 units Lantus (long-acting insulin) one time a day, and 500 mg Metformin HCl (Hydrochloride) (oral medication used to control high blood sugar) twice a day. The physician's orders included, Call MD when blood sugars < (lesser than) 70 mg/dL or > 400 mg/dL. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the December 2023 blood sugars log identified a reading of 67 mg/dL on 12/27/23. The progress notes identified, * 04/24/24, . Residents blood sugar was 62 [mg/dL] this morning. * 04/26/24, . Residents blood sugar was 65 [mg/dL] this morning. A progress note, dated 04/27/24, further identified the facility transferred Resident #86 to the emergency room after she received Glucagon (medication used to treat low blood sugar) for a blood sugar reading of 42 mg/dL. Review of the medical record showed staff failed to notify Resident #86's physician of the low blood sugar readings on 12/27/23, 04/24/24, and 04/26/24. 27221

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 27221 Based on record review, review of Medicare Part A letters/notices, and staff interview, the facility failed to ensure the resident and/or their representative completed the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) for 1 of 3 supplemental residents (Resident #16) discharged from Medicare Part A in the past six months. Failure to ensure the completion of the SNFABN limited the resident/representative's ability to exercise their rights regarding Medicare Part A services. Findings include: Review of Medicare Part A beneficiary notices identified Resident #16 discharged from Medicare Part A on 04/03/24. The SNFABN failed to identify if the resident and/or her representative chose to continue or discontinue services or request a demand bill. Review of Resident #16's medical record occurred on 07/11/24. The record lacked documentation the resident and/or representative was informed of options related to billing and services when Medicare Part A coverage ended. During an interview on the morning of 07/11/24, an administrative staff member (#1) confirmed staff failed to document whether staff informed Resident #16 and/or her representative of their options related to billing and services when Medicare Part A coverage ended.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28398 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 5 of 12 sampled residents (#1, #3, #13, #15, and #25). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION GG: FUNCTIONAL ABILITIES AND GOALS The Long-Term Care Facility RAI Manual, revised October 2023, pages GG-14, GG-15, and GG-21, states . Individualized care plans should be based on an accurate assessment of the resident's self-performance and the amount and type of support being provided to the resident. Steps for Assessment 1. Assess the resident's self-care performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. CMS [Centers for Medicare & Medicaid Services] anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period. A dash (-) indicates 'No information.' CMS expects dash use to be a rare occurrence. - Review of Resident #3's medical record occurred all days of survey and included diagnoses of hemiplegia (partial or total paralysis on one side of the body) and hemiparesis (one-sided muscle weakness caused by brain, spinal cord, or nerve problems) following cerebral infarction (stroke) affecting left dominant side. Resident #3's quarterly MDS, dated [DATE], showed Section GG with dashes in the areas of oral hygiene, upper and lower body dressing, putting on footwear, and transfers. The MDS failed to identify the resident's ability or assistance required in these areas. - Review of Resident #13's medical record occurred all days of survey. The record identified diagnoses of Parkinson's disease (progressive disorder that affects the nervous system and causes tremors, stiffness, and slow movement) with dyskinesia (uncontrolled, involuntary movements of the face, arms or legs) and dementia. Resident #13's quarterly MDS, dated [DATE], showed Section GG with dashes in the areas of oral hygiene, toileting hygiene, showering/bathing, upper body dressing, lower body dressing, and putting on/taking off footwear. The MDS failed to identify the resident's ability or assistance required in these areas. - Review of Resident #15's medical record occurred on all days of survey and included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #15's annual MDS, dated [DATE], showed Section GG with dashes in the areas of oral hygiene, toileting, upper and lower body dressing, putting on footwear, personal hygiene, and transfers. The MDS failed to identify the resident's ability or assistance required in these areas. - Review of Resident #25's medical record occurred on all days of survey and included diagnoses of pain in left shoulder, polyneuropathy (damage to multiple peripheral nerves), and abnormalities of gait and mobility. Resident #25's quarterly MDS, dated [DATE], showed Section GG with dashes in the areas of oral hygiene, bathing, upper and lower body dressing, putting on footwear, and transfers. The MDS failed to identify the resident's ability or assistance required in these areas. During an interview on 07/10/24 at 2:12 p.m., an administrative nurse (#6) agreed staff failed to code the MDS correctly for Residents #3, #13, #15, and #25. SECTION K: SWALLOWING/NUTRITIONAL STATUS The Long-Term Care Facility RAI Manual, revised October 2023, page K-10, states, . K0520. Nutritional Approaches: Check all of the following nutritional approaches that apply . Performed while a resident of this facility and within the last 7 days . B. Feeding tube . C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) D. Therapeutic diet (e.g. low salt, diabetic, low cholesterol) . Review of Resident #1's medical record occurred all days of survey. The physician's orders identified a feeding tube, Osmolite (type of tube feeding formula), and a pureed (mechanically altered) diet. Resident #1's quarterly MDS, dated [DATE], identified a therapeutic diet, and failed to identify a feeding tube or a mechanically altered diet. During an interview on 07/11/24 at 9:20 a.m., a dietary manager (#3) agreed staff failed to code the MDS correctly for Resident #1. 46963 46259

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46259 THIS IS A REPEAT DEFICIENCY FROM THE COMPLAINT SURVEY COMPLETED ON 03/12/24. Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect residents' current status for 2 of 12 sampled residents (Resident #17 and Resident #25). Failure to update care plans limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled Care Plan-R/S [rehab/skilled], LTC [long-term care], Therapy & Rehab occurred on 07/11/24. This policy, dated November 2023, stated, . POLICY . Each resident will have an individualized, person-centered, comprehensive plan of care . Any problems, needs and concerns identified will be addressed through the use of departmental assets, the Resident Assessment Instrument (RAI) and review of the physician's orders. This plan of care will be modified to reflect the care currently required/provided for the resident. - Review of Resident #17's medical record occurred on all days of survey. The current care plan stated, The resident has an ADL [activities of daily living] self care performance deficit only in bathing, otherwise, is independent. Date Initiated: 11/03/2023 Revision on: 11/21/2023 . A quarterly Minimum Data Set (MDS), dated [DATE], identified the resident required setup or cleanup assistance for eating and partial/moderate staff assistance for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The facility failed to updated Resident #17's care plan to reflect the care needs and staff assistance required. During an interview on 07/11/24 at 10:20 a.m., an administrative staff member (#1) confirmed staff failed to revise the care plan to reflect the changes in ADLs. - Review of Resident 25's medical record occurred on all days of survey. The current care plan, dated 04/26/24, stated, . The resident is at risk for falls R/T [related to] Osteoporosis and abnormalities of gait and mobility E/B [evidenced by] history of falls, hx [history] of femur fracture prior to admit. Modify to maximize safety. Observations on 07/09/24 and 07/10/24 showed a fall mat placed on the floor beside the resident's bed. Review of progress notes showed the following: *10/09/23 at 3:37 p.m., . Encouraged to wait for staff to help to prevent another fall. Falls mat @ [at] bedside. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*02/22/24 at 10:59 p.m., . Found resident sitting on the floor by her bed on top of the mat by her bed. *05/29/24 at 4:42 a.m., . Steady on feet and will attempt to self transfer. Falls [sic] mat @ [at] bedside. Resident #25's care plan failed to address the use of a fall mat at bedside. During an interview on 07/11/24 at 10:26 a.m., an administrative staff member (#1) confirmed staff failed to revise the the care plan to reflect the use of a fall mat. 46963

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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. 46259 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/08/23. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received adequate supervision/assistance to prevent accidents for 1 of 1 sampled resident (Resident #15) observed during a sit-to-stand lift transfer. Failure to ensure proper use of a leg strap as care planned placed Resident #15 at risk for possible injury. Findings include: Review of the facility policy titled Safe Resident Handling Equipment-Competency Validation Checklist occurred on 07/11/24. This policy, dated March 2023, stated, . Checks resident care plan or Kardex prior to transfer for type of equipment to be used, type and size of sling and amount of assistance required . If directed by care plan or location specific procedure, uses the shin/calf strap when the resident requires additional lower extremity support . Applies the shin/calf strap when the resident is in a seated position, before rising to a standing position. - Review of Resident #15's medical record occurred on all days of survey. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, muscle spasm, and polyneuropathy. The current care plan stated, . TRANSFER - Transfer Between Surfaces: Use SS-M [sit-to-stand lift with medium sling] with leg strap, assist of 1 for transfers. Observation on 07/09/24 at 11:10 a.m., showed a certified nurse aide (CNA) (#2) transferred Resident #15 from the bed to the toilet using the sit-to-stand lift. The CNA applied the sling to the resident and fastened the buckle then attached the sling to the lift. The CNA cued the resident to hold onto the lift bars and to place their feet on the platform. The CNA lifted the resident to a standing position, transferred to the bathroom and lowered to the toilet. After toileting, the CNA lifted the resident to a standing position, completed cares, and transferred the resident to the wheelchair. The CNA failed to apply the leg strap during transfers between surfaces. During an interview on 07/11/24 at 10:26 a.m., an administrative staff member (#1) confirmed the staff should apply the leg strap as care planned for the resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 28398 Based on observation and review of facility policy, the facility failed to ensure a medication error rate of less than five percent for 1 of 7 residents (Resident #7) observed during medication administration. Two medication errors occurred during staff administration of 25 medications, resulting in an eight percent error rate. Failure to properly prepare and administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of the facility policy titled Medication: Insulin Administration, Insulin Pens, Insulin Pumps occurred on 07/11/24. This policy, dated 12/14/23, stated, . Insulin Pen . Remove the protective pull tab from the needle and screw it onto the pen . Remove both the plastic outer cap and inner needle cap. 10. Turn the dosage knob to '2' units to prime pen. 11. Holding the pen with the needle pointing upwards, press the button until at least a drop of insulin appears. Inject the dose into the chosen site. Be sure to wait about 6 seconds to ensure that the full dose has been delivered. Observation of medication administration on 07/10/24 at 7:43 a.m. showed a nurse (#9) prepared a Levemir (long-acting) insulin pen and a Fiasp (rapid-acting) insulin pen for Resident #7. The nurse applied a needle, dialed each pen to two units, and held each pen horizontally to prime the insulin pen. After injecting the insulin, the nurse (#9) removed the needle from the skin immediately. Failure to prime an insulin pen correctly and inject the insulin with proper technique may result in the resident receiving less than the full dose.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 28398 Based on observation, review of facility policy, and staff interview, the facility failed to ensure accurate labeling of medications in 1 of 2 medication carts (300/400 cart) observed during medication administration. Failure to obtain a label for an insulin pen and identify an open date may result in a resident receiving an incorrect or ineffective dose of insulin. Findings include: Review of the facility policy titled Medication: Insulin Administration, Insulin Pens, Insulin Pumps occurred on 07/11/24. This policy, dated 12/14/23, stated, . Insulin Pen . Insulin pens must be clearly labeled with the name or other identifiers to verify that the correct pen is used on the correct person. Verify provider order, the expiration date and the number of days the pen has been open. - Observation on 07/10/24 at 8:17 a.m. showed a nurse (#5) prepared Resident #15's Humalog insulin pen for administration. The nurse obtained the pen from a bin labeled with the resident's name. The pen lacked a label with the resident's name or other identifying information and lacked an open date. - Observation on the morning of 07/10/24, during a check of insulin pens in the 300/400 wing medication cart, identified Resident #136's Tresiba (long-acting) insulin pen lacked an open date. During an interview on 07/10/24 at 8:30 a.m., a nurse (#5) stated, Whoever opens a pen is supposed to date it when opened.

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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. 28398 Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 2 of 2 sampled residents (Resident #1 and #3) observed with enhanced barrier precautions (EBP). Failure to practice infection control standards by ensuring staff use the proper personal protective equipment (PPE) has the potential to transmit infections to residents, staff, and visitors. Findings include: Review of the facility policy titled Standard and Transmission-Based Precautions, All Service Lines occurred on 07/11/24. This policy, revised 04/02/24, stated, . Purpose . To prevent the spread of infection . Enhanced Barrier Precautions . Enhanced barrier precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [multi drug resistant organisms] . Enhanced barrier precautions are needed for . Residents with Indwelling Medical devices (. indwelling urinary catheters, feeding tubes .) . - Review of Resident #1's medical record occurred on all days of survey. Current physician's orders included tube feeding formula/water flushes and gastrostomy (artificial opening into the stomach) tube site care daily and as needed (PRN). Observation on 07/09/24 at 3:11 p.m. showed Enhanced Barrier Precautions signs on Resident #1's doorframe and on top of the supply cart in the room. A nurse (#4) performed hand hygiene and gloved, flushed Resident #1's feeding tube, administered a PRN medication, then flushed and capped the tube. The nurse removed the soiled dressing from the gastrostomy tube site, cleansed the area, applied a new dressing, and performed hand hygiene and glove changes where indicated. The nurse (#4) failed to wear a gown as required. 46259 -Review of Resident #3's medical record occurred on all days of survey. The current care plan stated, . The resident requires Enhanced Barrier Precautions (EBP) R/T [related to] indwelling medical device suprapubic catheter . Don gown and gloves when performing high contact care activities including: dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing, device care and/or use, and wound care. Observation on 07/09/24 at 10:45 a.m. showed Resident #3 completing exercises with a restorative nursing aide (#7) in the therapy room. The aide proceeded to complete exercises with the resident's hands, shoulders, and feet. The aide (#7) failed to donn the appropriate PPE as required. Observation on 07/09/24 at 3:50 p.m., showed two certified nurse aides (CNAs) (#2 and #8) emptied Resident #3's catheter bag. The CNAs donned gloves, performed cares, doffed their gloves, sanitized their hands, and exited the room. The CNAs failed to don gowns as required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/11/24 at 10:26 a.m., an administrative staff (#1) confirmed staff should don PPE as required.