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	08/21/2025

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

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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 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. Based on review of facility policy, review of call light logs, and resident, family, and staff interviews, the facility failed to ensure sufficient nursing staff and related services are available at all times to meet the residents' needs for 2 of 8 sampled residents (Resident #30 and #39), one supplemental resident (Resident #26) and 1 confidential resident (Resident A) who required staff assistance. Failure to provide sufficient staffing does not promote each resident's rights, physical, mental, and psychosocial well-being, and/or provide a safe environment for the residents. Findings Include: Review of the facility policy titled Call Light occurred on 08/20/25. This policy, revised 07/08/25, stated, When residents call light is observed/heard, go to the resident's room promptly. Respond to request as soon as possible. Resident and family interviews occurred on the morning/afternoon of 08/18i25 and identified the following: * Resident A stated they are short of staff here, it takes 30 minutes to answer my call light. * Resident #26 stated it can take 30 minutes for staff to answer my call light. * Resident #30 reported it has been up to half an hour or more before staff answer the call light, identified having to wait on the toilet a long time, and “they forget about me. *Resident #30's family member identified concerns with call lights being answered timely on various shifts, and Resident #30 has waited up to an hour for staff to answer the call light and has had urinary incontinence due to waiting. *Resident #39 stated, it can take 45 minutes to get my call light answered and I talked to staff, and nothing changed. Review of the call light logs from 08/14/25 to 08/18/25 showed the following and call light response: * Resident #39 waited 25 minutes or greater on 7 occasions and the longest wait 50 minutes. * Resident #26 waited 25 minutes or greater on 6 occasions and the longest wait 53 minutes. *The call light logs from 7/17/25 to 8/18/25 showed Resident #30 waited 17 to 22 minutes or greater on 9 occasions and the longest wait 27 minutes. During an interview on the morning of 08/21/25 an administrative nurse (#1) confirmed the call light (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	log showed staff failed to answer call lights promptly. During confidential staff interviews on 08/20/25 at 11:03 a.m., confidential staff members (B, C, D, E, F) stated the staff worked short most shifts, administration was aware, and the shortages continued in resident care areas and in the dining room with feeding assistance.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure food is prepared and stored in a clean and sanitary manner in 2 of 2 kitchen/nutrition centers (main kitchen and nutrition center) observed. Failure to ensure cleanliness of the kitchen and proper food storage has the potential for contamination of food and may result in a foodborne illness to residents, visitors, and staff. Findings include: The 2022 Food and Drug Administration (FDA) Food Code, Chapter 4, Section 4-6, pages 20-21, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, stated, . (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (C) Non FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. Review of the facility policy titled Food Preparation -Food and Nutrition occurred on 08/19/25. This policy, dated March 2025, stated, . Regular cleaning/sanitizing of equipment, utensils and work surfaces are performed during food preparation as needed . Observation of the main kitchen occurred on 08/18/25 at 12:55 p.m. with dietary staff member (#8) and showed the following:* An accumulation of dirt and debris on the floor, and a large, blackened area under the three-compartment sink.* An accumulation of a sticky substance on the lip of the oven hood.* An accumulation of a sticky substance on the outside of all the cabinet doors within the kitchen.* An accumulation of food residue on the back splash and walls behind the food prep area and food prep sink.* An accumulation of debris in the utensil and other storage drawers that contain food and miscellaneous dishware. * An accumulation of a sticky yellow substance around the inside rims of a silverware divider within a utensil drawer.* Visible dried particles of red colored food on pan covers on a storage shelf.* Visible food debris on the bottom of the reach in refrigeration unit, along with a sticky dark pink substance on the sides and bottom of the unit.* The reach in freezer unit contained a large unopened bag of onion rings with layers of ice buildup within the bag.* One ceiling fan with an accumulation of dust and hanging debris in the dishwashing area.The walk-in refrigerator showed:*An accumulation of grey-green mold on the underside of the two-fan condenser unit.*An accumulation of debris on all the metal wired shelving units.The walk-in freezer showed: * One open, unlabeled, and undated bag of chicken cordon blue.* One open, unlabeled, and undated bag of skinless chicken breast.* One open, unlabeled, and undated bag of hushpuppies.*Observation of the nutrition freezer on 08/19/25 at 12:52 p.m. showed a large blue gel ice pack stored beside ice cream cups.During an interview on 08/20/25 at 11:23 a.m., a dietary staff member (#8) stated he expected staff to clean all areas of the kitchen and store food properly.

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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. Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plans to reflect the residents' current status for 2 of 14 sampled residents (Resident #12 and #28). Failure to update care plans limited staffs' ability to communicate needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled Care Plan occurred on 08/20/25. This policy, revised December 2024 stated, . The plan of care will be modified to reflect the care currently required/provided for the resident. -Observation on 8/18/25 at 4:00 p.m. showed a certified nurse aide (CNA) (#3) transferred Resident #28 from the wheelchair to the bathroom using a sit to stand mechanical lift. Review of Resident #28's medical record occurred on all days of survey. The care plan stated, Pivot transfer with one assist using the gait belt for toileting.Transfer: Resident requires AX1 [assist times one] staff to stand pivot transfer with gait belt. During an interview on 08/20/25 at 1:09 p.m. a staff nurse (#4) confirmed Resident #28 transferred using a sit-to-stand lift. -Review of Resident #12’s medical record occurred on all days of survey and showed a weight loss of greater than 10% in one month. The care plan, stated, The resident has unplanned/unexpected weight loss R/T [related to] (SPECIFY) E/B [evidenced by] (SPECIFY) Resident will maintain weight between (SPECIFY: _____ and _____ lbs.) by review date. Weigh (SPECIFY FREQ. [Frequency])” The care plan failed to include interventions and goals related to Resident #12's weight loss.

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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. Based on observation, record review, review of facility policy, and staff interview, the facility to ensure residents received adequate supervision/assistance to prevent accidents for 1 of 1 sampled resident (Resident #30) observed during a sit-to-stand lift transfer. Failure to ensure proper use of a leg strap placed Resident #30 at risk for possible injury.Findings include:Review of the facility policy titled Safe Resident Handling Equipment-Competency Validation Checklist occurred on 08/21/25. This policy, dated December 2024, 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 #30's medical record occurred on all days of survey. Diagnoses included muscle weakness and orthopedic pain. The current care plan stated, . TRANSFER: The resident requires staff assist for 1 for toileting and transfers with the stand lift. The care plan failed to address the need for a shin strap.Observation on 8/19/25 at 3:58 p.m. showed a certified nurse aide (CNA) (#11) transferred Resident #30 from the wheelchair to the bathroom using the sit to stand mechanical lift. The CNA failed to attach the leg strap and place the resident's shins against the shin rests. During the transfer, the resident's legs shifted and buckled, hands failed to grip the handlebars, and his/her arms/elbows pushed outward and upward. The CNA failed to apply the leg strap during transfer and notify the nurse of the resident's unsafe transfer. During an interview on 08/21/2025 at 12:43 p.m., an administrative nurse (#5) confirmed Resident #30 transferred using a sit-to-stand lift, and she expected staff to report any resident change in transfer status.

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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. Based on observation and staff interview, the facility failed to discard expired medications in 2 of 3 medication storage areas (100-200 Wing Medication Cart and Medication Storage Room) reviewed. Failure to discard expired medications may result in decreased effectiveness of the prescribed medication.Findings include:-Observations on 08/19/25 at 1:40 p.m. of the medication storage room showed the following:* Three saline solution laxatives expired in December 2024.* Two tubes of antimicrobial skin wound gels expired in November 2024.* One bottle of antiseptic liquid for skin wounds expired in March 2025.-Observation on 08/19/25 at 1:50 p.m. of the medication cart (100-200 wing) showed one bottle of nystatin powder expired December 2024.During an interview on 08/20/25 at 2:57 p.m., an administrative nurse (#1) confirmed expired medication should be discarded and not used.