STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Bottineau	725 E 10th St Bottineau, ND 58318

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the facility policy, and staff interview, the facility failed to ensure safe transfers for 2 of 7 sampled residents (Residents #1 and #34) and 1 of 1 supplemental resident (Resident #22) observed during transfers. Failure to assess the need for mechanical lifts and to use a gait belt placed residents at risk of serious injury.Findings include: Review of the facility policy titled Mobility Support and Positioning occurred on 09/11/25. This policy, dated 04/06/25, stated, . Always check the Kardex, or care plan/service plan prior to the transfer or repositioning task for type and amount of assistance needed. Follow any specific lift/transfer instructions for the resident. -Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, TRANSFER . Total lift (Hoyer lift) with assist of 2 staff and large sling for transferring in/out of bed. Observation on 09/11/25 at 7:00 a.m. showed a certified nurse aide (CNA) (#3) placed a mechanical sit to stand lift outside the door of Resident #1's room. During an interview on 09/11/25 at 7:00 a.m., when asked if any residents on the 300 hallway required a Hoyer lift, the CNA (#3) stated, No, they [residents] are located in the other wing. During an interview on 09/11/25 at 7:20 a.m., the CNA (#3) stated she used the sit to stand lift to transfer Resident #1 from the bed. During an interview on 09/11/2025 10:44 a.m., an administrative nurse (#1) stated she would expect the CNAs to follow the current care plan and use a total lift with assist of two staff to transfer Resident #1 from the bed. -Review of Resident # 22's medical record occurred on all days of survey. The current care plan stated, . TRANSFER - Transfer Between Surfaces: With total lift x2 [with two] staff . Resident is unable to weight bear with total lift assist x 2 . During an observation on 09/09/25 at 4:15 p.m., two CNAs (#11 and #12) transferred Resident #22 from the recliner to a wheelchair. One CNA (#11) applied a gait belt and both CNAs (#11 and #12) attempted to stand the resident. The resident could not bear weight and the CNAs lifted him with the gait belt to the wheelchair. One CNA (#11) stated, he was a [mechanical] lift but today they [administrative staff] said he can pivot. During an observation on 09/11/25 at 5:30 a.m., a CNA (#13) assisted Resident #22 with toileting. The CNA (#13) positioned the resident's wheelchair next to the toilet, directed the resident to hold onto (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the grab bar, and assisted the resident to stand by placing her hands under the resident's armpits and lifting. The CNA (#13) then called for assistance to transfer the resident off of the toilet. The CNA (#13) and the nurse (#14) directed the resident to hold onto the grab bar and assisted the resident to stand by lifting under the resident's arms. The CNA (#13) and nurse (#14) failed to utilize a mechanical lift or a gait belt. -Review of Resident #34's medical record occurred on all days of survey. Diagnoses included osteoporosis and history of a healed traumatic fracture. The current care plan stated, . The resident has an ADL self-care performance deficit . E/B needs assist . TRANSFER - assist of 1 staff with transfers . During an observation on 09/08/2025 at 4:15 p.m., a CNA (# 3) assisted the resident to toilet using a stand lift. The CNA failed to transfer the resident as care planned. During an interview on 09/11/25 at 10:45 a.m. an administrative staff member (#1) confirmed the facility allowed CNAs to decide whether to use a lift, they can always go up [use a lift] but they can't go down [not use a lift] if care planned but confirmed she expected staff to use a gait belt with all pivot transfers. The facility failed to have a nurse assess and update the care plan for a change in resident's condition requiring the use or discontinuation of a mechanical lift. 2. Based on observation, record review, review of facility policy, and resident and staff interviews, the facility failed to ensure an environment free of accidents and hazards for 2 of 2 sampled residents (Resident #2 and #26) observed with a door alarm and cleaning chemicals in the room. Failure to ensure a functioning door alarm for Resident #2 placed the resident at risk for falls/injury. Failure to ensure Resident #6's room remained free from chemicals placed the residents at risk for injury. Findings include: Review of facility policy titled Alarms- Bed, Chair, and Door occurred on 09/11/25. This policy, dated August 2025, stated, . Nursing staff will be responsible for visually checking placement of alarms . Review of facility policy titled Housekeeping, Standard or Light Cleaning occurred on 09/11/25. This policy, dated August 2025, stated, . No Cleaning supplies . should be . in the resident rooms. Review of the Safety Data Sheet for Ecolab carpet spray remover, dated 08/26/19, stated, . Causes serious eye irritation. Avoid contact with skin and eyes . - Observation on all days of survey showed a spray bottle of Ecolab carpet spot remover located on Resident #26's bed side table. During an interview on 09/11/25 at 1:40 p.m., an administrative staff member (#10) stated, Chemicals should not be left in resident rooms. - Review of Resident #2's medical record occurred on all days of survey. The care plan stated, . resident has an ADL [Activities of Daily Living] self-care performance deficit . mobility deficits, shuffled gait . Alarm to door to alert staff when resident comes out of his room . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 9/11/25 at 5:31 a.m. showed Resident #2 ambulated out his room into the hallway without the door alarm sounding. The resident walked across the hall, approached a CNA (#18) and stated, Bathroom. The CNA assisted the resident back to his room and activated the resident's call light for assistance. At 5:36 a.m., a nurse (#19) answered the resident's call light and the CNA (#18) reported to the nurse the door alarm was not hooked up. The facility staff failed to ensure Resident #2's door alarm remained connected. During an interview on 9/11/25 at 1:30 p.m., an administrative staff member (#1), stated she expected staff to ensure Resident #2's door alarm was connected. Review of Resident #1's medical record occurred on all day of survey and identified diagnoses including other poly-osteoarthritis, adult failure to thrive, and secondary malignant neoplasm of the breast. The current care plan stated, TRANSFER . Total lift with assist of 2 staff and large sling for transferring in/out of bed. Observation on 09/11/25 at 7:00 a.m. showed a certified nurse aide (CNA) (#3) parked a mechanical sit to stand lift outside the door of Resident #1's room. During an interview on 09/11/25 at 7:00 a.m. a CNA (#3), when asked if any residents on the 300 hallway required a Hoyer lift (full body lift), the CNA stated, No, they are located in the other wing. During an interview on 09/11/25 at 7:20 a.m. the CNA (#3), stated, she used the sit to stand lift to transfer Resident #1 from the bed to the wheelchair. During an interview on 09/11/2025 10:44 a.m., an administrative nurse (#1) stated she would expect the CNAs to follow the current care plan and use a total lift with assist of two staff for transferring Resident #1 from the bed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, review of facility policy, and staff interview the facility failed to follow standards of infection control for 5 of 11 sampled residents (Resident #4, #5, #26, #34, and #48) and 3 supplemental residents (Resident #19, #22 and #40) observed during cares. Failure to follow infection control practices during resident cares related to handling soiled linen, hand hygiene, glove use, and enhanced barrier precautions (EBP) has the potential to spread infection throughout the facility.Findings include: Review of the facility policy titled Hand Hygiene occurred on 09/11/25. This policy, dated March 2022, stated, . To establish hand hygiene as the single most important factor in preventing the spread of disease-causing organisms to patients and personnel in healthcare settings . Procedure . use waterless alcohol-based hand sanitizer or soap and water to clean their hands . When entering patient room . If gloves are used to perform a . procedure, hand hygiene must be completed before donning [applying] gloves . After removing gloves regardless of task completed . When moving from contaminated body site to a clean body site during patient care . When exiting patient room. Review of the facility policy titled Standard, Enhanced Barrier, and Transmission Based Precautions occurred on 09/11/25. This policy, dated July 2025, stated, . Enhanced barrier precautions expand the use of personal protective equipment [PPE] . and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multi-drug-resistant organisms (MDROs) to staff hands and clothing. Enhanced barrier precautions are also used for residents with chronic wounds . and residents with indwelling urinary catheters . High -contact resident care activities include transfers, dressing, providing hygiene, changing briefs or assisting with toileting . changing linens, indwelling medical device care or use . and wound care. -Observation on 09/09/25 at 3:45 p.m. showed Resident #4 ambulating down the hallway with their pants and brief sliding down. A certified nurse aide (CNA) (#3) placed an ungloved hand between the resident's skin and brief and pulled the brief/pants up. Without performing hand hygiene, the CNA sat in a chair and began typing on a computer. - Observation on 09/09/25 at 9:52 a.m. showed CNA (#3) entered Resident #5's room to assist with toileting. Without performing hand hygiene, the CNA applied gloves and transferred the resident to the toilet. The CNA removed the gloves, applied new gloves, completed perineal cares, applied a clean brief, and pulled up the resident's pants. The CNA removed the soiled gloves and without performing hand hygiene, applied clean gloves and transferred the resident back into the wheelchair. The CNA (#3) removed the gloves and performed hand hygiene. The CNA (#3) failed to perform hand hygiene after removing the soiled gloves and applying clean gloves. - Observation on 09/09/25 at 1:41 p.m., showed two CNAs (#2 and #3) entered Resident #19's room to provide incontinence cares. The CNA (#3) failed to perform hand hygiene before entering the room. After completing incontinence cares, the CNA (#3) removed the soiled gloves, bagged the soiled linen and exited the room. The CNA (#3) failed to perform hand hygiene and exited the room. The CNA (#2) removed the soiled gloves, removed the wheelchair from the room, reentered the room and performed hand hygiene. -Review of Resident #22's medical record occurred on all days of survey. The current care plan (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated, . The resident requires Enhanced Barrier Precautions (EBP) R/T [related to] indwelling medical device- catheter . [NAME] [apply] 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 09/11/2025 at 5:35 a.m. showed a CNA (#13) entered Resident #22's room without performing hand hygiene and without applying a gown. The CNA applied gloves and assisted the resident to the toilet. At 5:55 a.m., a nurse (#14) entered Resident #22's bathroom without applying a gown to assist the CNA (#13) with perineal cares and transfer back into the wheelchair. Without performing hand hygiene, the nurse removed gloves from their pocket, completed the resident's perineal cares, pulled the resident's pants up, and assisted the CNA (#13) to transfer the resident back into the wheelchair. The CNA and the nurse then removed their gloves and performed hand hygiene. The CNA (#13) and the nurse (#14) failed to apply gowns before completing high contact cares and failed to perform hand hygiene after perineal cares. -Review of Resident #26's medical record occurred on all days of survey. The current care plan stated, . The resident requires Enhanced Barrier Precautions R/T open wound . [NAME] [apply] gown and gloves when performing high contact care activities including . checking and changing . Observations of Resident #26 showed the following:*09/08/25 at 3:51 p.m., two CNAs (#16 and #17) applied gowns, and without performing hand hygiene, applied gloves, entered the resident's room, and provided incontinent cares. During cares, the CNA (#16) discarded a soiled brief and soiled gloves into the trash can and without performing hand hygiene, obtained gloves from their own pocket, applied the gloves, and transferred the resident with a hoyer lift. *09/09/25 at 1:23 p.m., Two CNAs (#2 and #3) performed hand hygiene, applied gloves, failed to apply gowns, and provided incontinent cares for the resident. During cares, the CNA (#2) removed one glove and asked the CNA (#3) for a clean glove. The CNA (#3) removed a handful of gloves from their pocket, which fell onto the resident's bed. The CNA (#2) picked up one glove from the bed and applied without performing hand hygiene. The CNA (#3) picked up the remaining gloves from the resident's bed and placed them back into her pocket. The CNAs (#2, #3, #16, and #17) failed to perform hand hygiene between glove changes, apply clean gloves, and apply gowns before completing Resident #26's cares. -Observation on 09/08/25 at 4:15 p.m. showed a CNA (#3) applied gloves without performing hand hygiene and transferred Resident #34 from a wheelchair to the toilet utilizing a sit to stand lift. The CNA removed the resident's soiled brief, placed the brief into a trash can, and lowered the resident onto the toilet. The CNA (#3) removed her gloves, and without performing hand hygiene, applied clean gloves, removed the trash bag from the can, and removed her gloves. Without performing hand hygiene, the CNA applied clean gloves, performed perineal cares, applied a clean brief, pulled up the resident's pants, removed her gloves and transferred the resident back into the wheelchair. The CNA removed the lift sling, straightened the resident's clothing, and exited the room with the lift. The CNA (#3) returned to the resident's room, carried the trash bag to a soiled utility room down the hallway, and then performed hand hygiene. The CNA (#3) failed to perform hand hygiene between glove changes, after completing perineal cares, before moving on to other tasks, and before exiting the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Observation on 09/11/25 at 7:33 a.m. showed a medication aide (MA) (#7) entered Resident #40's room with medications. The resident was in the bathroom at the time, so the MA applied gloves, removed the soiled linen and garbage room the room, and placed them in the soiled utility room. The MA (#7) returned to the room and failed to perform hand hygiene. -Observation on 09/09/25 at 8:17 a.m. showed a CNA (#12) transferred Resident #48 into the bathroom. Without performing hand hygiene, the CNA (#12), applied gloves, removed resident's soiled shirt and soiled brief, and performed perineal cares. Without removing her soiled gloves, the CNA applied a clean brief, removed the resident's soiled shoes, socks, and pants, cleansed the resident's legs, and then removed the soiled gloves. Without performing hand hygiene, the CNA applied new gloves and dressed the resident. During an interview on 9/11/25 at 10:45 am, an administrative staff member (#1) stated she expected staff to perform hand hygiene before entering and exiting resident rooms, between glove changes, after resident cares, and apply gowns/gloves when providing high contact cares for residents on EBP.

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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. 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 18 sampled residents (Resident #19) 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 include:Review of the facility policy titled Call Light occurred on 09/11/25. This policy, dated July 2025, stated, . PURPOSE to ensure residents always have a method of calling for assistance . when leaving the room, place call light within easy reach of resident.During an observation on 09/08/25 at 4:18 p.m., Resident #19 asked this surveyor, Can you give me that call light back there? I want to lay down. Observation showed the resident's call light not within reach. Observation on 09/08/25 at 5:05 p.m. showed Resident #19's call light remained out of reach and at 5:15 p.m., staff assisted the resident to the dining room. Observation on 09/09/25 at 1:41 p.m. showed two certified nurse aides (CNAs) (#2 and #3) assisted Resident #19 with a transfer. The CNAs failed to place the resident's call light within reach before exiting the room. During an interview on 09/11/25 at 1:30 p.m., an administrative staff member (#1) confirmed she expected staff to place the residents' call light within reach prior to exiting the room.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and staff interview, the facility failed to report an alleged violation of abuse and neglect to the State Survey Agency (SSA) for 1 of 2 residents (Resident #36) with an unwitnessed fall resulting in an injury and hospital admission. Failure to report alleged incidents to the SSA placed Resident #36 and other residents at risk for possible abuse and/or injury.Findings include:Review of the facility policy titled Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy & Rehab occurred on 09/10/25. This policy, dated, 04/04/25, stated, . PURPOSE To ensure that all identified events of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported .Review of Resident #36's medical record occurred on all days of survey. Diagnoses included non-Alzheimer's dementia. An admission Minimum Data Set (MDS), dated [DATE], identified moderate cognitive impairment.Review of progress notes identified the following:* 09/03/25 at 05:46 p.m., Date and Time of event: 9-3-25 @0405 (at 4:05 a.m.) . resident found slumped against the door to their bathroom with their head and shoulders leaning against the door. Obvious laceration with active bleeding to right frontal/parietal skull.additional laceration to R [right] rear parietal/occipital skull noted. Bleeding to scalp . Resident's v/s [vital signs] obtained and found to be hypoxic [inadequate oxygen level] initial SpO2 [peripheral oxygen saturation] was 68 RA [room air]. Resident unsure of how they fell or why they were up. * 09/03/25 at 10:08 a.m., stated, . Spoke with ER [emergency room] and notified that resident was admitted to the hospital for pneumonia.* 09/04/25 at 9:42 a.m., stated, . hospital notified facility of resident's death.During an interview on 09/11/25 at 12:56 p.m., an administrative staff member (#4) identified the facility completed an internal investigation, did not find the injury to be significant or of unknown origin, and did not complete a Facility Reported Incident (FRI) notification.The facility failed to identify Resident #36's injury as potential abuse or neglect and submit an incident report to the SSA.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a Significant Change in Status Assessment (SCSA) for 2 of 2 of sampled residents (Resident #2 and #5) who experienced a significant change in status. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status and identity and implement appropriate care approaches.Findings include:The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.19.1), dated October 2024, page 2-24 stated, . A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. Page 2-27 stated, A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. Any decline in an ADL [activities of daily living] physical functioning area (e.g., self-care or mobility) (at least 1) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individual's functioning. - Review of Resident #2's medical record occurred on all days of survey. A SCSA Minimum Data Set (MDS), dated [DATE], identified no wandering, partial/moderate assist with toileting, bathing, and lower body dressing, and supervision with upper body dressing and putting on/taking off footwear.A quarterly MDS, dated [DATE], identified wandering 1-3 days, substantial/maximum assistance with toileting, bathing, lower and upper body dressing, and putting on/taking off footwear.- Review of Resident #5's medical record occurred on all days of survey. An annual MDS, dated [DATE], identified no mood indicators, no behaviors, wandering 1-3 days, substantial/maximum assistance with lower body dressing, and partial/moderate assistance with roll left to right (bed mobility).- A quarterly MDS, dated [DATE], identified 0-3 mood indicators, verbal behaviors 4-6 days, other behaviors 1-3 days, wandering 4-6 days, dependent with lower body dressing, and substantial/moderate assistance with roll left to right.The record lacked evidence facility staff identified and/or completed a SCSA related to Resident #2's and #5's change in behaviors and decline in ADLs.During an interview on 09/10/25 at 4:22 p.m., an administrative staff nurse (#5) confirmed Resident #2 and Resident #5 declined and staff should have completed a SCSA.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 12 sampled residents (Resident #2, #5, and #21) reviewed. Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION C: COGNITIVE PATTERNSThe Long-Term Care Facility RAI User's Manual, revised October 2024, page C-24, of the RAI Manual stated, . If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.,) and staff were unable to make a determination based on observation of the resident, use the standard 'no information' code (a dash, '-'), to indicate that the information is not available because it could not be assessed. SECTION D: MOODThe Long-Term Care Facility RAI User's Manual, revised October 2024, page D-3, of the RAI Manual stated, . If the resident interview was not conducted within the look-back period . item D0100 must be coded 1, Yes, and the standard 'no information' code (a dash '-') entered in the resident interview items. SECTION GG: FUNCTIONAL ABILITIESThe Long-Term Care Facility RAI User's Manual, revised October 2024, page GG-14, of the RAI Manual stated . 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. Page GG-21 stated . A dash (-) indicates No information. CMS [Centers for Medicare & Medicaid Services] expects dash use to be a rare occurrence.- Review of Resident #2's medical record occurred on all days of survey. A quarterly MDS, dated [DATE], showed Section C and D dashed. The factors listed on page C-24 of the RAI manual did not apply to Resident #2. The facility failed to assess the resident's cognitive abilities and mood. - Review of Resident #5's medical record occurred on all days of survey. A quarterly MDS, dated [DATE], showed Section C, D and GG dashed. The facility failed to assess the resident's cognitive abilities, mood, and functional abilities.During an interview on 09/09/25 at 11:11 a.m., an administrative staff member (#5), stated, If nursing staff doesn't complete those assessments I use dashes.SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMSThe Long-Term Care Facility RAI User's Manual, revised October 2024, page O-7, stated, . O0110K1, Hospice care code residents identified as a being in a hospice program for terminally ill persons . - Review of Resident #21's medical record occurred on all days of survey. A physician's order dated 06/27/25. stated, Admit to skilled nursing facility under HOSPICE care. The current care plan stated, . The resident has a terminal prognosis . Is on hospice care . The facility failed to code hospice services on the admission MDS, dated [DATE].During an interview on 09/11/25 at 8:15 a.m., an administrative staff member (#5) confirmed staff failed to code hospice on Resident #21's MDS.

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	355093	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Bottineau	725 E 10th St Bottineau, ND 58318

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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 record review, review of professional reference, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 2 of 18 sampled residents (Resident #3 and Resident #6). Failure to update care plans limited the staff's ability to communicate needs and ensure continuity of care.Findings include:Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice, 11th ed., Pearson Education Inc., New Jersey, pages 203 and 212, stated, . The nurse uses . care plans. creates an individual plan for unusual . problems needing special attention. Observations include assessments made to determine whether a complication is developing. The nurse should write observations for both real problems and those for which the client is at risk.-Review of Resident #3's medical record occurred on all days of survey. Diagnoses included diabetes, and a physician's order for insulin. The resident's care plan lacked monitoring for signs/symptoms and interventions for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar).-Review of Resident #6's medical record occurred on all days of survey. Diagnoses included diabetes and a physician's order for glipizide (an oral antidiabetic). The resident's care plan lacked monitoring for signs/symptoms and interventions for hypoglycemia and hyperglycemia.During an interview on 09/11/2025 at 10:44 a.m., an administrative nurse (#1) stated staff failed to update the care plans for Resident #3 and Resident #6.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, review of facility policy, review of manufacturer's instructions, review of professional reference and staff interview, the facility failed to ensure staff followed professional standards of practice for 1 of 2 supplemental residents (Resident #3) observed during medication administration. Failure to properly prepare insulin pens (Resident #3) may result in residents receiving the wrong medication dose and/or result in adverse health consequences.Findings include:Review of the facility policy titled Medication: Insulin Administration, Insulin Pens, Insulin Pumps 09/05/24, stated, Intermediate or mixed insulins (. 70/30 .) . This type of insulin should be gently mixed before use. To mix, roll the pen between your hands. You must also turn the pen up and down ten times .Review of manufacturer's instructions for the NovoLog 70/30 Mix FlexPen, dated February 2023, stated, . roll NOVOLOG MIX 70/30 FlexPen gently between hands in a horizontal position 10 times. Then, turn NOVOLOG MIX 70/30 FlexPen upside down so that the glass ball moves from one end of the reservoir to the other 10 times until the suspension appears uniformly white and cloudy. Inject immediately.- Observations during medication administration showed the following:- 09/11/25 at 7:18 a.m. a medication aide (MA) (#7) primed the insulin pen and immediately administered Novolog mix 70/30 to Resident #3 (a combination insulin containing 70 percent immediate acting insulin and 30 percent rapid acting insulin) insulin without following the mixing protocol. During an interview on 09/11/25 at 1:30 p.m., a staff nurse (#1) stated she was unaware of the mixing process for a Novolog 70/30 insulin pen.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide treatment and services to aid in the healing of a pressure ulcer for 1 of 2 sampled residents (Resident #26) with a current pressure ulcer. Failure to implement interventions as ordered may result in a new pressure area and delayed healing/deterioration of an unstageable pressure ulcer.Findings include:Review of the facility policy titled Pressure Ulcers occurred on 09/11/25. This policy, dated 02/17/25, stated, . A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing. Review of Resident #26's medical record occurred on all days of survey. Diagnoses included diabetes mellitus and protein calorie malnutrition. A quarterly Minimum Data Set (MDS), dated [DATE], identified dependent on staff with rolling from side to side (bed mobility) and transfers, and an unhealed unstageable pressure ulcer. The current care plan stated, . The resident has pressure ulcer to sacral area. offer/assist to turn/reposition at least every 2 hours. Provide open heel boots to bilateral feet or float heels on pillow . A physician's order, dated 11/03/23, stated bilateral pressure relieving boots on while in bed and in chair.Observations on 09/09/25 showed Resident #26 seated in a wheelchair in the hallway by the nurses station from 8:08 a.m. until 1:23 p.m. (over 5 hours) without being repositioned. At 1:23 p.m. two certified nurse aides (CNAs) (#2 and #3) assisted Resident #26 with a check and change. Observation showed the pressure ulcer dressing to the coccyx soiled with bowel movement (BM). The CNA (#2) used a wipe to clean the BM from the resident's dressing. After cares the resident remained in bed, and the CNAs exited the room. The CNAs failed to notify the nurse of the soiled dressing and apply the pressure ulcer relieving boots.Observation on 09/09/25 at 3:51 p.m. showed Resident #26 remained in bed without pressure relieving boots or heels floated.During an interview on 09/09/25 at 5:23 p.m., a nurse (#22) stated the CNAs (#2 and #3) failed to report Resident #26's soiled dressing. Observation on 09/10/25 at 8:45 a.m. showed Resident #26 in bed without pressure relieving boots or heels floated. Observation on 09/10/25 at 10:20 a.m. showed two nurses (#6 and #23) changed Resident #26's pressure ulcer dressing. When completed, the resident remained in bed and the nurses exited the room without placing the pressure relieving boots or floating his heels on a pillow. Review of Resident #26's repositioning documentation from 08/12/25 to 09/09/25 showed the following: 1 day - occurred two times.9 days - occurred three times.14 days - occurred 4 times.5 days - occurred five times.The number of hours between repositioning ranged from 2-24 hours. During an interview on 9/11/25 at 1:30 p.m., an administrative staff member (#1) stated she expected staff to turn and reposition residents every two hours, place pressure relieving boots when ordered, and care planned.

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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. Based on observation, record review, facility policy review, and staff interview, the facility failed to provide appropriate toileting for 1 of 5 sampled residents (Resident #2) observed during toileting. Failure to provide timely toileting may result in a loss of dignity and placed the resident at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and fall and/or injuries.Findings include:Review of the facility policy titled Activities of Daily Living occurred on 09/11/25. This policy, dated 12/23/24, stated, . Any resident who is unable to carry out activities of daily living will receive necessary services to maintain . grooming and personal and oral hygiene.Review of Resident #2's medical record occurred on all days of survey. The care plan identified the following, . TOILET USE: Resident requires assist of 1 staff. TOILETING PROGRAM: Offer resident the toilet every 2 hours when awake . BRIEF USE: . Check Q2 [every] 2 hours and prn [as needed]. During an observation on 09/09/25 at 3:05 p.m., a certified nurse aide (CNA) (#9) assisted Resident #2 to the bathroom. The resident's incontinent product and shorts were saturated with urine. Review of the resident's toileting log for 09/09/25 showed staff last assisted the resident with toileting at 11:31 a.m. (3.5 hours prior).Review of Resident #2's toileting log, dated 08/13/25 through 09/10/25, showed additional five occasions, (08/13/25, 08/16/25, 08/17/25, 09/05/25, 09/07/25) when staff failed to toilet the resident every two hours. The occasions ranged from 4 to 11 hours between toileting times and resulted in urinary and bowel incontinence. During an interview on 09/11/25 at 1:30 p.m., a nurse (#1) stated, If a resident is in a brief, the expectation is to check and change them every two hours.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on record review and staff interview, the facility failed to ensure resident records contained the hospice election form for 1 of 1 sampled resident (Resident #21) receiving hospice services. Failure to obtain the form limits staff's ability to ensure coordination of care between the facility and the hospice. Findings include:Review of Resident #21's medical record occurred on all days of survey and identified Resident #21 elected hospice services on 06/27/25. The care plan stated, . The resident . Is on hospice care .The medical record lacked the hospice election form.During an interview on 09/11/25 at 12:30 p.m., an administrative staff member (#20) confirmed the medical record lacked the hospice election form.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, review of facility policy, and resident and staff interviews, the facility failed to provide a safe, sanitary, and comfortable environment for 2 of 18 sampled residents (Resident #5 and #26), and 2 of 5 supplemental residents (Resident #14 and #19). Failure to ensure residents' fans, walls, and wheelchairs are clean, and failure to remove non-working refrigerators in resident rooms may affect the well-being, comfort, health, and safety of the residents.Findings include: Review of the facility policy titled Housekeeping, Standard or Light Cleaning occurred on 09/11/25. This policy, dated 08/21/25, stated, . PURPOSE To provide procedures for the proper, daily cleaning of resident rooms . thorough, routine, and high-quality cleaning procedures are necessary to minimize the prevalence of infection. Review of the facility policy titled Standard, Enhanced Barrier, and Transmission-Based Precautions occurred on 09/11/25. This policy, dated 07/07/25, stated, . Standard precautions are based on the principle that all . body fluids, secretions, . may contain transmissible infectious agents. Observations on all days of survey showed a thick layer of dust on the personal fan in Resident #26's room and an unidentified brown substance on the wall beside the resident's bed. During an interview on 09/08/25 at 1:08 p.m., Resident #26 stated he could not use the bed pan for bowel movements, I blew it all over, look at the wall it's still on there. - Observation on all days of survey showed a refrigerator located in Resident #14 and #19's room. The refrigerator emitted a strong foul odor. The thermometer in the refrigerator read 78 degrees Fahrenheit. Both residents stated it was not their refrigerator, and Resident #19 stated, It was my prior roommates. - Observation on 09/09/25 at 9:52 a.m. showed food crumbs on Resident #5's wheelchair. A certified nurse aide (CNA) (#3) assisted the resident from the toilet, and without cleaning the cushion placed the resident back in the soiled wheelchair. -Observation of Resident #6's room on 09/09/25 at 10:00 a.m., showed crumbs covering the wheelchair seat pad and a shirt laying on the floor. During an interview on 09/11/25 at 1:40 p.m., two administrative staff members (#1 and #10) stated they expected staff to clean resident fans weekly, clean dirty walls, and remove nonfunctioning appliances immediately from resident rooms.