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	03/11/2026

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

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 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 interviews, the facility failed to follow infection control standards for 4 of 8 sampled residents (Resident #8, #15, #34, and #36) and 1 supplemental resident (Resident #37) observed during cares. Failure to follow infection control standards related to 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, Standard, Enhanced Barrier, and Transmission-Based Precautions, All Service Lines occurred on 03/11/26. This policy, revised 07/07/25, stated, Standard precautions include hand hygiene, the use of personal protective equipment . textile and laundry handling practices . Enhanced barrier precautions expand the use of personal protective equipment 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 multidrug-resistant organisms to staff hands and clothing. Enhanced barrier precautions are also used for residents with . pressure ulcers . High-contact resident care activities include transfers, dressing . providing hygiene, changing briefs . changing linens . Review of the facility policy titled, Hand Hygiene occurred on 03/11/26. This policy, revised 11/13/25, stated, . HCW [health care workers] will use waterless alcohol-based hand sanitizer or soap and water to clean their hands: When entering the patient room . before donning gloves . after removing gloves . when moving from contaminated body site to a clean body site during patient care . when exiting a patient room . - Review of Resident #8'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] pressure ulcer . Observations showed the following: * 03/09/26 at 8:48 a.m., an EBP sign on Resident #8's door frame and Resident #8 rested in bed. A certified nurse aide (CNA) (#4) delivered Resident #8's meal tray. Without applying a gown or gloves, the CNA (#4) adjusted Resident #8's legs, torso, bedding, raised the head of the bed to an upright seated position, and assisted the resident the meal. After Resident #8 finished the meal, the CNA (#4) applied gloves, removed the resident's brief, and provided perineal cares. The CNA removed the soiled gloves, and without performing hand hygiene, applied new gloves, applied a new brief, and removed the resident's shirt and bilateral heel protectors. The CNA (#4) removed the soiled gloves, and without performing hand hygiene or applying new gloves, dressed Resident #8, placed a pillow under the resident's hip, adjusted the blankets and combed the resident's hair. The CNA (#4) gathered the garbage, and without performing hand hygiene, exited the room with the meal tray and garbage. The CNA (#4) failed to apply a gown prior to completing high-contact resident cares, failed to wear gloves during all high-contact cares, and failed to perform hand hygiene prior to glove application, after (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removing gloves, and prior to exiting the room. * 03/09/26 at 12:15 p.m., Resident #8 rested in bed. Two CNAs (#3 and #4) entered the resident's room and the CNA (#4) applied gloves, removed Resident #8's wet brief, and provided perineal care. The CNA (#4) removed the soiled gloves, and without performing hand hygiene, applied new gloves, and placed a clean brief and pants on Resident #8. The CNA (#3) applied gloves and assisted the CNA (#4) to place a transfer sling under Resident #8. Using a full body mechanical lift, the CNAs (#3 and #4) transferred the resident to a wheelchair. The CNA (#4) adjusted Resident #8 in the wheelchair and removed the soiled gloves. The other CNA (#3) wiped down the lift with a disinfecting wipe, removed the soiled gloves, performed hand hygiene, pushed the lift into the hallway, re-entered the room, combed the resident's hair, and without performing hand hygiene escorted Resident (#8) out of the room. The CNA (#4) made Resident #8's bed, gathered the garbage, performed hand hygiene and exited the room. The CNAs (#3 and #4) failed to apply a gown prior to completing high-contact resident cares, failed to wear gloves during all high-contact cares, and failed to perform hand hygiene prior to applying gloves, and after removing gloves. * 03/09/26 at 3:06 p.m. showed Resident #8 seated in a wheelchair. A CNA (#4) performed hand hygiene, applied a gown and gloves, gathered supplies to provide colostomy (an opening in the abdominal wall, connecting the colon to an external pouch to divert stool) cares, and placed a washable cloth protector on Resident #8's lap. The CNA (#4) emptied the colostomy bag into a graduate, emptied, rinsed, and stored the graduate. The CNA (#4) removed the soiled gloves, and without performing hand hygiene, applied new gloves, wiped the colostomy bag with a wet washcloth, and sealed the colostomy bag. The CNA placed the soiled washcloth and cloth protector directly onto the floor. The CNA (#4) removed the soiled gown and gloves, and without performing hand hygiene, applied new gloves, removed Resident #8's soiled shirt, added it to the laundry pile on the floor, and placed a new shirt on the resident. The CNA gathered the garbage, placed the soiled laundry into a separate garbage bag, removed the soiled gloves, performed hand hygiene and escorted the resident out of the room. The CNA (#4) failed to complete hand hygiene between glove changes, removed the gown prior to completing cares and placed soiled laundry directly on the floor. - Observation on 03/09/26 at 7:55 a.m. showed Resident #37 seated on the toilet. A CNA (#1) entered the room, performed hand hygiene, applied gloves, completed hygiene cares, removed the soiled gloves, and dressed the resident. The CNA (#1) assisted the resident into a chair and exited the resident room. The CNA (#1) failed to perform hand hygiene after removing the soiled gloves and assisting with other tasks and before exiting Resident #37's room. - Observation on 03/09/26 at 11:17 a.m. showed a CNA (#1) transferred Resident #34 onto the toilet with a mechanical sit to stand lift. The CNA (#1) left the bathhouse without performing hand hygiene. The CNA (#1) returned to the bathhouse, and without performing hand hygiene, applied gloves, provided toileting hygiene, adjusted the resident's clothes, and transferred the resident back to the wheelchair. The CNA (#1) removed the soiled gloves, and without performing hand hygiene, put on one new glove, cleaned the lift, removed the glove, and without performing hand hygiene, pushed Resident #34 to hallway. - Observation on 03/09/26 at 11:31 a.m. showed the CNA (#1) transported Resident #36 from the solarium to the bathhouse. Without performing hand hygiene, the CNA applied gloves, utilized the sit to stand lift, and placed the resident on the toilet. The CNA (#1) provided perineal cares, applied a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	new brief and clothing, and removed the soiled gloves. Without performing hand hygiene, the CNA applied one glove, cleansed the lift with a disinfecting wipe, removed the glove, and without performing hand hygiene, pushed the resident into the hall. The CNA (#1) then went back to Resident #36's room, returned with a sweater, and helped the resident put the sweater on. - Observation on 03/09/26 at 11:42 a.m. showed Resident #15 seated in a wheelchair in the bathhouse. Two CNAs (#1 and #5) applied gloves, used a sit to stand lift to assist the resident to stand, removed the resident's soiled brief, and sat the resident on the toilet. The CNA (#5) cleansed the front perineal area, removed the soiled gloves, and without performing hand hygiene, used the lift control to operate the lift, and assisted the resident to stand. The CNA (#1) cleansed the buttocks area, adjusted the brief/pants, removed the soiled gloves, and without performing hand hygiene, continued cares. The CNA (#5) applied gloves, cleansed the lift with a disinfecting wipe, gathered the garbage, and without performing hand hygiene, both CNAs exited the bathhouse. During an interview on 03/10/26 at 3:30 p.m., an administrative nurse (#2) stated she expected staff to perform hand hygiene when entering and exiting rooms, in-between glove changes, and follow EBP precautions.

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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. Based on review of Medicare Part A letters/notices and staff interview, the facility failed to ensure the resident and/or their representative received the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) and the Notice of Medicare Non-Coverage (NOMNC) at least two days prior to the end of services for 1 of 3 residents (Resident #45) reviewed for termination of Medicare Part A services. Failure to ensure the resident and/or their representative received the SNFABN and NOMNC at least two days prior to the end of skilled services 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 #45 discharged from Medicare Part A on 11/28/25. The SNFABN and the NOMNC showed the resident signed the forms on 11/28/25. The facility failed to provide the forms at least two days before the Medicare A services ended.During an interview on 03/10/26 at 11:48 a.m., an administrative staff member (#3) confirmed staff failed to provide the SNFABN and the NOMNC forms at least two days in advance.

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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, and facility policy review, facility staff failed to properly utilize assistive devices necessary to prevent accidents for 1 of 2 sampled residents (Resident #34) observed during a pivot transfer. Failure to use a gait belt during a transfer placed the resident at risk for injury and/or pain.Finding Include: Review of the policy titled Safe Resident Handling Program (SRHP) Resource Packet - . LTC [Long Term Care] . occurred on 03/11/26. This policy, dated 07/07/25, stated, . Follows resident plan of care (Kardex)/service plan for mobility device, . The Care Plan is part of the communication process to the caregiver. Ambulation: (SPECIFY: X staff assist, mobility device and harness size, and any restrictions) and (SPECIFY assist device: Gait belt, walker etc.). Review of the policy titled Ambulation of Resident . LTC . Ambulation of Resident Clinical Skill Checklist occurred 03/11/26. This undated policy, stated, 1. Review resident information on the PCC [point click care] Kardex/Care Plan. 5. Use gait belt, if not contraindicated, around resident's waist. Review of Resident #34's medical records occurred on all days of survey. The care plan stated, Focus: The resident has an ADL self care performance deficit R/T [related to] weakness, failure to thrive E/B [evidenced by] difficulty performing ADLs . Interventions: . SRHP - Transfer - Transfer Between Surfaces: assist of 1 staff with use of walker. Has episodes of weakness and is unable to transfer safely without sit to stand as needed. The care plan did not identify a gait belt as contraindicated for Resident #34.Observation on 03/09/26 at 11:12 a.m. showed resident #34 seated in a recliner in the solarium. A certified nurse aide (CNA) (#1) placed the wheelchair with an arm rest at a 90-degree angle to the left arm rest of the recliner and locked the brakes. The CNA (#1) assisted the resident to reach across the wheelchair and take hold of the arm rest on the far side of the wheelchair with his left hand. The CNA (#1) then told the resident to stand and grabbed on and under his right arm. Resident #34 continued to hold onto the wheelchair while leaning to the left, which caused the recliner and wheelchair to slide left. The CNA (#1) stated, Come on [Resident #34's name], gave another pull on the resident's right arm and pulled him over the right arm rest to the wheelchair seat. The CNA (#1) put her face into the resident's line of site and said, You hurt my back. the resident smiled at the CNA (#1). The CNA (#1) failed to use a walker and a gait belt as care planned and per policy.