STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Larimore	501 E Front St Larimore, ND 58251

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy/procedure review, and staff interview, the facility failed to provide the necessary treatment/services to promote healing and prevent the worsening of pressure ulcers for 2 of 2 sampled residents (Residents #2 and #3) with pressure ulcers. Failure to consistently implement interventions to prevent worsening of an existing pressure ulcer and identify changes resulted in delayed treatment and deterioration of the resident's pressure ulcers. Findings Include:Review of the facility policy titled, Physician/Practitioner Orders occurred on 11/05/25. This policy, dated 04/06/25, stated, . PURPOSE: To provide individualized care to each resident by obtaining appropriate, accurate and timely physician/practitioner orders. To provide a procedure that facilitates the timely and accurate processing of physician/practitioner orders . POLICY: Verbal/Telephone orders will be taken only by a licensed nurse . who will enter the order promptly into PCC [point click care-electronic medical record] . PROCEDURE: Physician/Practitioner orders are a critical component to providing quality care to residents. The nursing services and health information management (HIM) departments each have responsibilities for processing physician/practitioner orders in a timely and accurate manner.The facility failed to provide a policy for processing referrals to an outside agency.- Review of Resident #2's medical record occurred on 11/05/25 and identified an admission date of 10/16/25. A nursing note, dated 10/16/25 at 2:57 p.m., stated, . Resident admitted from . Hospital . Res [resident] has pressure ulcers to left ankle and sacrum. The care plan identified, . The resident has 2 pressure ulcers on admit - coccyx and ankle. An intervention, dated 10/27/25, stated, . Encourage, assist, supervise with use of assist bar, trapeze bar, etc. for resident to assist with turning. Physician's orders, dated 10/31/25, included:*Rotate (reposition) every two hours*Prevalon (protective padded boot) boot when in bedThe medical record failed to show staff repositioned Resident #2 every two hours and applied the Prevalon boots as ordered. During an interview on 11/05/25 at 5:02 p.m., an administrative staff member (#1) confirmed Resident #2's medical record lacked documentation of repositioning and application of Prevalon boots.- Review of Resident #3's medical record occurred on 11/05/25 and identified and admission date of 9/12/25 with a diagnosis of spinal cord compression. The physician's admission orders failed to identify a pressure ulcer or pressure ulcer treatment. On 9/16/25 (4 days after admission) a nursing note identified deep tissue injuries (DTI) (pressure-induced damage to underlying tissues) to both buttocks. The facility obtained wound care orders on 09/17/25. Modifications to wound care orders occurred on 09/26/25, 10/09/25, and 10/20/25.Resident #3's care plan identified assistance of two staff members required for bed mobility. A wound assessment, dated 09/25/25, stated to reposition the resident every 2-3 hours and as needed (PRN) however, the facility failed to add this intervention to the care plan until 10/15/25, approximately one month after identifying the DTI.The medical record lacked evidence staff repositioned Resident #3 every 2-3 hours and as needed.Review of Resident #3's medical record identified the following:*09/16/25 . DTI to R) [right] buttock . Length 3.2 cm [centimeter] . Width 1.1 cm . Calmoseptine [an ointment used to treat skin irritations] and Mepilex [an absorbent dressing] apply 3x/week [three times per] and PRN. The nurse identified the assessment as the initial assessment. *09/25/25 . DTI on both buttocks . Length 3.2 cm . Width 1.1 cm . Depth 0.1 cm . L) [left] buttock 4.4 cm x [by] 3 cm x 0.2 cm .*10/02/25 . Pressure ulceration . Length 4 cm . Width 3.5 cm . Depth 0 cm . Is drainage present on the dressing? Yes. Is there drainage leaking around the dressing? Yes. Describe the condition of tissue surrounding the dressing: Purulent [a thick fluid that is a sign of infection]. Describe: Purulent, blackening tissue, malodorous [unpleasant smell] . Additional information . Dr [name] office contacted in regards to concerns of wound complication. Awaiting further orders .*10/04/25 . Pressure ulcer progressed and both buttocks open . Length 9 cm .Width 8 cm . Depth 0.2 cm . ulcer to noted to be progressed and size increased from last assessment . Comments: . Pro Source . BID [twice a day] to enhance wound healing . Dr. [name] updated on wound progressing . (The bilateral buttock wounds merged into one sacral wound at this point).*10/07/25 at 9:43 a.m. Communication/Visit with Physician Late Entry: . Dr [name] at bedside visiting with resident . Review of the provider visit note failed to include reference of any skin issues or pressure ulcers.*10/08/25 . Pressure ulcer to Sacrum/buttocks . Comments: Fax sent to Dr. [name] wit [sic] wound updated to obtain order for wound clinic VA [veterans administration] referral . *10/11/25 at 5:40 p.m. Health Status . Late Entry: [entered into the electronic medical record on 10/24/25 at 12:18 p.m.] . Received order to refer resident to VA for wound care. Order entered and left voicemail for social worker to schedule