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	02/13/2025

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31725 Based on review of the facility reported incident and investigation documents, record review, policy review, and staff interview, the facility failed to protect the resident's right to be free from abuse from 1 of 1 sampled resident (Resident #10) who displayed sexual behaviors towards other residents. Failure to protect residents from sexual abuse may result in fear, anxiety, mental anguish, and physical injury. Findings include: Review of the facility policy titled Abuse and Neglect - Rehab/Skilled occurred on 02/12/25. This policy, revised 07/22/24, stated, . Purpose . To ensure that residents are not subjected to abuse by anyone, including, but not limited to . other residents . To ensure that all identified incidents of alleged or suspected abuse/neglect . are promptly reported and investigated. Review of Resident #10's medical record occurred on all days of survey. A Minimum Data Set (MDS), dated [DATE], identified severe cognitive impairment. The care plan, dated 10/05/24, stated, The resident has displayed inappropriate sexual advances towards another resident . Resident will be redirected when exhibiting inappropriate sexual advances . Contact health care provider to report new behavior and seek input - Monitor the involved residents and know their whereabouts - Provide involved residents with opportunities for socialization in supervised areas - Touching female resident: tell him to stop, immediately re-direct and report to nurse. Review of the facility investigation report occurred on 02/11/25. This report, dated 10/5/24, stated, [Resident #10] approached a female resident [initials] seated in wheelchair in hallway by nurse's station and touched her breast. Incident witnessed by staff member who immediately intervened saying '[Resident #10] you cannot do that / that's inappropriate' and [Resident #10] removed his hand from the resident's breast. Female resident showed no response to being touched. This report included interviews from other female residents and stated: *[Female resident's name] . '[Resident #10], he is one of the residents here, has touched my leg before (as she says this points to top middle of her thigh). I told him to stop and he did.' . (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*[Female resident's name] - . '[Resident #10] has touched me on my leg before (as she says this she points to her thigh.) I told him don't do that, and he stopped.' . [Female resident's name] also reported that '[Resident #10] has asked me if he could touch me before (pointing at her breasts) and I said no, so he went on' . 'it's only been happening for a month now.' . Review of Resident #10's progress notes identified the following: *11/01/24 at 1:49 p.m. Resident was seen by staff member touching a female residents leg. Writer visited with resident about what staff had reported when asked he admitted that he had touched her [sic] stated 'she likes it' writer explained that it is inappropriate to touch her or any ladies in the facility. *01/02/25 at 3:57 p.m. Resident was seen rubbing a female residents upper thigh in the dining room during lunch. Interaction was immediately stopped and the residents were separated. Daughter was notified about the incident. Education provided to [Resident #10] about appropriate behavior. During an interview on the morning of 02/13/25, a nurse (#5) stated Resident #10's interactions on 11/01/24 and 01/02/25 have been with Resident #12. Review of Resident #12's medical record occurred on all days of survey and identified a diagnosis of dementia. The MDS, dated [DATE], identified short-and-long term memory problems. The facility failed to recognize Resident #10's behaviors as sexual abuse and implement/update interventions to prevent the behaviors.

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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 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** 31725 Based on record review, review of facility policy, and staff interview, the facility failed to report incidents of resident-to-resident abuse to the State Survey Agency (SSA) for 1 of 1 sampled resident (Resident #10) who exhibited sexual behaviors. Failure to report incidents of sexual abuse may result in unwanted physical and/or sexual contact and may cause all residents to experience fear, anxiety, and psychosocial harm. Findings include: Review of the facility policy titled Abuse and Neglect - Rehab/Skilled occurred on 02/12/25. This policy, revised 07/22/24, stated, . Purpose . To ensure that residents are not subjected to abuse by anyone, including, but not limited to . other residents . To ensure that all identified incidents of alleged or suspected abuse/neglect . are promptly reported and investigated. Designated agencies will be notified . including the State Survey and Certification Agency. Review of Resident #10's medical record occurred on all days of survey. A Minimum Data Set (MDS), dated [DATE], identified severe cognitive impairment. The care plan, dated 10/05/24, stated, The resident has displayed inappropriate sexual advances towards another resident . Review of Resident #10's progress notes identified the following: *11/01/24 at 1:49 p.m. Resident was seen by staff member touching a female residents leg. Writer visited with resident about what staff had reported when asked he admitted that he had touched her [sic] stated 'she likes it' writer explained that it is inappropriate to touch her or any ladies in the facility. *01/02/25 at 3:57 p.m. Resident was seen rubbing a female residents upper thigh in the dining room during lunch. Interaction was immediately stopped and the residents were separated. Daughter was notified about the incident. Education provided to [Resident #10] about appropriate behavior. The facility failed to report the above incidents to the SSA. During an interview on the afternoon of 02/12/25, a supervisory nurse (#1) stated staff failed to inform her of Resident #10's behavior on 01/02/25.

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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** 28398 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 12 sampled residents (#14, #15, and #183). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2024, pages I-5 and I-8, stated, . Active Diagnoses in the Last 7 Days - Check all that apply . Coding Instructions: Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status . during the 7-day look-back period . - Review of Resident #14's medical record occurred on all days of survey. The care plan stated, The resident has indwelling catheter R/T [related to] urine retention E/B [evidenced by] need for catheter. Date initiated: 12/11/2023 . A physician's progress note, dated 10/17/24, listed the diagnosis of benign prostatic hyperplasia (BPH) with urinary obstruction and chronic indwelling Foley catheter. The annual MDS, dated [DATE], identified an indwelling catheter, but failed to indicate a related diagnosis. The Care Area Assessment (CAA) for Urinary Incontinence/Indwelling Catheter stated, Resident triggered CAA related to presence of Foley catheter. Staff monitor for pain/discomfort related to Foley and monitor for S/S [signs/symptoms] of UTIs [urinary tract infections]. Staff provide catheter care every shift. He is at risk for developing complications related to Foley. During an interview on 02/12/25 at 11:58 a.m., an MDS nurse (#5) agreed staff failed to code BPH and/or urinary obstruction on Resident #14's annual MDS. 45873 SECTIONS N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2024, pages N-6 to N-8, stated, . Code all high-risk drug class medications according to their pharmacological classification . N0415: High-Risk Drug Classes . Coding Instructions: . N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g. [example] aspirin/extended release . was taken by the resident at any time during the 7-day observation period. - Review of Resident #15's medical record occurred on all days of survey. Medications included daily aspirin. The facility failed to code the antiplatelet medication on the quarterly MDS, dated [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Review of Resident #183's medical record occurred on all days of survey. Medications included daily aspirin. The facility failed to code the antiplatelet medication on the quarterly MDS, dated [DATE]. During an interview on 02/13/25 at 11:50 a.m., administrative staff member (#1) confirmed facility staff failed to code antiplatelet use for Resident #15 and #183. 46477

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45873 Based on record review, review of facility policy, and staff interview, the facility failed to implement a baseline care plan to fully reflect the resident's needs for 1 of 2 sampled residents (Resident #179) newly admitted to the facility. Failure to develop and implement a complete baseline care plan may result in care that is inconsistent with residents' needs. Findings include: Review of the facility policy titled Comprehensive Care Plan And Care Conferences occurred on 02/13/25. This policy, dated 01/31/25, stated, . Baseline Care Plan. If utilized, review the Pre-Admission Data Collection and other admission information . to develop an initial care plan that includes specific interventions including but not limited to: Initial goals . physician orders . and resident-specific care. Review of Resident #179's medical record occurred on all days of survey and identified an admitted [DATE]. Diagnoses included diabetes and hydrocephalus (accumulation of fluid in the brain). Physician's orders included, Lantus Solo Star (Insulin) . Inject 40 unit . one time a day for blood sugar and Acetazolamide [a diuretic medication] ER [Extended Release] . Give 500 mg by mouth two times a day for obstructive hydrocephalus. The resident's base line care plan, dated 02/03/25, stated, . The resident is on diabetic therapy . Monitor resident condition based on clinical practice guidelines or clinical standards of practice r/t [related to] use of acetazolamide . Resident #179's care plan incorrectly identified Acetazolamide as a treatment for diabetes, failed to address the use of insulin and interventions for blood sugar irregularities, and failed to correctly identify the use of a diuretic and interventions for complications of hydrocephalus. During an interview on 02/13/25 at 11:50 a.m., two administrative staff members (#1 and #2) confirmed staff failed to develop an accurate baseline care plan for Resident #179.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 31725 45873 46477 Based on record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 4 of 12 sampled residents (Resident #3, #15, #24, and #183). Failure to update care plans limited the staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled Comprehensive Care Plan And Care Conferences occurred on 02/13/25. This policy, dated 01/31/25, stated, . The care plan is driven by identified resident issues/conditions and their unique characteristics, strengths and needs. In addition to updates during a care plan review, care plans must be revised as the resident's needs/status changes. - Review of Resident #3's medical record occurred on all days of survey. A physician's order, dated 12/03/24, stated, FSBS (Finger Stick Blood Sugar) 2 times a day and PRN as needed . Oxygen . at night . The care plan stated, . The resident has altered respiratory r/t [related to] need for O2 [oxygen] at all times . The care plan failed to identify Resident #3's blood sugar checks and to revise the oxygen needs. During an interview on 02/13/25 at 10:02 a.m., an administrative staff member (#2) confirmed staff failed to update Resident #3's care plan. - Review of Resident #15's medical record occurred on all days of survey. The care plan identified Enhanced Barrier Precautions (EBP) but the medical record failed to include a diagnosis or problem related to the need for EBP. Physician orders included, oxycodone (a narcotic pain medication) oral tablet 5 milligrams (MG) Give 5 mg by mouth every 12 hours as needed for moderate or severe pain. The care plan failed to identify the problem and interventions related to pain control. - Review of Resident #24's medical record occurred on all days of survey. Physician orders included, furosemide (a diuretic medication) oral tablet 20 MG Give 2 tablet by mouth one time a day for edema. The care plan failed to identify the problem and interventions related to edema. During an interview on 02/13/25 at 10:23 a.m., an administrative staff member (#2) confirmed staff failed to update Resident #15's and Resident #24's care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of Resident #183's medical record occurred on all days of survey. A physician's order, dated 8/22/24, stated, 2000 cc [a unit of measurement] fluid restriction to be divided as follows: 1000 cc-Dietary, 500cc-Nursing, day shift, 500cc eve [evening]/NOC [night] . Document amount received q [every] shift. The current care plan stated, . Resident meets criteria for protein calorie malnutrition dx [diagnosis] and R/T [related to] current diet . 200 cc fluid rst. [restriction]. The facility failed to correctly state Resident #183's fluid restriction on the care plan. During an interview on 02/13/25 at 11:50 a.m., an administrative staff member (#2) confirmed Resident #183's care plan was incorrect.

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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. 31725 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision for 1 of 1 sampled residents (Resident #16) who smoked. Failure to ensure the resident smoked outside in the designated area and to keep cigarettes and lighters locked in a cabinet placed all residents at risk for injury. Findings include: Review of the facility policy titled Smoking and Tobacco Use occurred on 02/12/25. The policy, dated 11/27/24, stated, . Smoking and tobacco use inside Society-owned buildings is not permitted . Smoking and tobacco use is permitted only in acceptable outdoor, location-designated areas. Review of the facility policy titled Smokers Policy occurred on 02/12/25. The policy, dated 12/24/24, stated, . Smoking is permitted in the smokers shed located on the North end of the building. It is not permitted to smoke anywhere else on this campus. Smoking is not permitted anywhere inside this building . Review of Resident #16's medical record occurred on all days of survey. The care plan stated, The resident uses tobacco products E/B [evidence by] smoking cigarettes . Check resident for lighter and cigarettes when returning from smoking . store cigarettes and lighter at nurse's station. A Tobacco Use Evaluation, dated 06/06/23, identified the resident as safe to smoke independently and indicated the resident could have two cigarettes at a time. Resident #16's progress notes stated: *12/12/24 at 9:11 a.m. Resident found smoking in Wellness Center entryway by CMA [certified medication aide]. She instructed resident to go outside to designated smoking area. Writer noted resident smoking just outside the wellness center door and talked to him about following the rules per our facility policy. *12/12/24 8:26 p.m. Resident found smoking in entryway between wellness center and outdoors. When found smoking, resident rolled his eyes at staff member, then snuffed cigarette out on carpet. Resident was informed that smoking is not in this area . This is the second time in less than 12h [hours] that resident has been caught smoking indoors. *12/14/24 6:47 a.m. resident in front of wellness center smoking. Resident wheelchair's back to the entrance door and is on the concrete slope. informed there is a designated smoking area he should be smoking [sic] for safety. Observation on the afternoon of 02/11/25 and the morning of 02/12/25 showed cigarettes and lighters stored in an unlocked storage room in an open box attached to the wall. The open box contained a lock with the key in the locking mechanism. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/12/25 at 12:01 p.m., an administrative staff member (#7) stated staff are expected to keep the box with the cigarettes and lighters closed and locked with the key kept in the nurse's medication cart. The staff member (#7) locked the box and handed the keys to a nurse (#3) and the nurse stated, I had not heard that. During an interview on the morning of 02/13/25, an administrative nurse (#2) stated Resident #16 should not smoke inside the facility or right next to the building.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46477 Based on observation, record review, review of a professional reference, and staff interview, the facility failed to provide appropriate toileting for 2 of 9 sampled residents (Resident #4 and #8) who required staff assistance with toileting. Failure to provide toileting may result in a loss of dignity and placed the residents at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and fall and/or injuries. Findings include: Kozier & Erb's Fundamentals of Nursing: Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 892, stated, Fecal and Urinary Incontinence: Moisture from incontinence promotes skin maceration [tissue softened by prolonged exposure to being wet or soaked] and makes the epidermis [skin] more easily eroded and susceptible to injury. Digestive enzymes in feces, urea in urine . also contribute to skin excoriation [area of loss of the superficial layers of the skin] . Any accumulation of secretions . is irritating to the skin, harbors microorganisms, and makes an individual prone to skin breakdown and infection. Page 1221 stated, Managing Urinary Incontinence . Habit training, also referred to as timed or prompted voiding and scheduled toileting, attempts to keep clients dry by having them void at regular intervals, such as every 2 to 4 hours. The goal is to keep the client dry . -Review of Resident #4's medical record occurred on all days of survey and included a diagnosis of multiple sclerosis (MS). The Minimum Data Set (MDS), dated [DATE], identified always incontinent of urine and frequently incontinent of bowel. The care plan stated, . The resident has an ADL [activities of daily living] self-care performance deficit R/T [related to] MS E/B [evidence by] needing assist. TOILETING: Toileting schedule: offer upon rising before and after meals, bedtime and prn [as needed] . The resident has bladder incontinence R/T decreased mobility and MS E/B frequently incontinent of bladder . The resident has impaired cognitive function R/T MS E/B poor safety awareness, some cognitive impairment. Observations showed the following: *02/11/25 at 10:58 a.m. The certified nurse aide (CNA #8) entered Resident #4's room and offered to toilet and reposition, and the resident refused. The CNA (#8) stated, this is a constant [referring to refusal of toileting] with [resident name], he is in the morning and then not until bed [referring to the time he will allow toileting or check and change]. *02/11/25 at 1:15 p.m. The CNA (#8) entered Resident #4's room and offered to toilet and reposition, and the resident refused. *02/11/25 at 2:59 p.m. The CNA (#8) entered resident #4's room and offered to toilet and reposition, and the resident refused. The CNA (#8) failed to check Resident #4's brief, encourage toileting or repositioning, provide education, or notify the nurse of the resident's refusal during the above observations. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's toileting record, dated January 14 - February 12, 2025, identified the following: *Two days, not checked/changed or toileted for 24 hours. *Twelve days, checked/changed or toileted one time in 24 hours. *Eleven days, checked/changed or toileted two times in 24 hours. *Five days, checked/changed or toileted three times in 24 hours. -Review of Resident #8's medical record occurred on all days of survey and included a diagnosis of bipolar disorder. The MDS, dated [DATE], identified frequently incontinent of urine and occasionally incontinent of bowel. The care plan stated, . The resident has bowel incontinence and needs assist and has loose stools at times . The resident has bladder incontinence and needs assist . The resident has an ADL self-care performance deficit R/T bipolar and no desire to complete tasks at times E/B need for assist .TOILET USE: Resident requires assist of 1 wears incontinent products . Toileting schedule: offer upon rising before and after meals, bedtime and PRN . Resident needs a lot of encouragement as refuse [sic] cares at times. needs assist with all incontinent episodes . The resident has impaired thought processes . E/B impaired judgment. Observations showed the following: *02/10/25 at 2:25 p.m. Resident #8 in bed and covered with blanket. The CNA (#8) asked if he had used the toilet today and the resident responded no. *02/11/25 at 11:45 a.m. Resident #8 sitting in dining room with a strong odor of feces. The CNA (#8) asked if he had used the toilet today and the resident responded no. *02/11/25 at 12:28 p.m. Resident #8 walked down the hallway to his room with feces on his shirt and pants and laid down in bed. *02/11/25 at 12:50 p.m. This surveyor asked the CNA (#8) to check on Resident #8 as he had soiled his shirt and pants. The CNA (#8) entered his room and asked the resident if he needed the bathroom, and the resident responded no. The CNA (#8) stated, I smell BM [bowel movement], let's go to the bathroom. The resident stated no and told the CNA to come back at 2:00 p.m. The CNA (#8) stated, the resident frequently refuses toileting cares and, all we can do is come back later. When asked about the facility procedure, the CNA thought about it and stated, I guess, I better let the nurse know. The nurse (#10) entered the room and with encouragement and education, assisted the resident to the bathroom. Review of Resident #8's toileting record, dated January 14 - February 12, 2025, identified the following: * Three days, not checked/changed or toileted for 24 hours. * Thirteen days, checked/changed or toileted one time in 24 hours. (continued on next page)

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	355097	A. Building B. Wing	02/13/2025

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Nine days, checked/changed or toileted two times in 24 hours. * Four days, checked/changed or toileted three times in 24 hours. * One day, checked/changed or toileted four times in 24 hours. During an interview on 02/12/25 at 10:49 a.m., when asked about Resident #4 and Resident #8's toileting record and observations, a nursing staff member (#3) stated, Staff are expected to let nursing know of any refusal of cares, and agreed, the resident's record lacked documentation of refusals.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 45873 Based on record review, policy review, and staff interviews, the facility failed to provide the care and services consistent with professional standards of practice for 1 of 1 sampled resident (#183) currently receiving dialysis. Failure to receive dialysis treatment communication may result in an unidentified change in the resident's condition. Findings include: Review of the facility policy titled Dialysis Services occurred on 02/13/25. This policy, dated 09/25/24, stated, . Care plan dialysis care specific to the resident: for example, unique nutritional needs or fluid restriction, avoid B/P [blood pressure] in arm with fistula, any other restrictions per provider. Provide education specific to the resident and their support system. Review of Resident #183's medical record occurred on all days of survey. A nursing order, dated 02/07/25, stated, Complete UDA [user defined assessment]: Clinical Monitoring - Dialysis: prior to departure of dialysis and after returning from dialysis two times a day every Mon, Wed, Fri [Monday, Wednesday, Friday] for dialysis monitoring. The current care plan stated, . The resident needs . hemodialysis R/T [related to] chronic kidney disease stage 4. Dialysis at [facility name] three times per week via fistula Lt [left] upper arm . Encourage resident to go for the scheduled dialysis appointments. Monday, Wednesday and Friday . Do not draw blood from Lt arm . Do not take blood pressure in Lt arm . Monitor/document/report to health care provider PRN [as needed] for s/s [signs/symptoms] of the following: Bleeding, hemorrhage, bacteremia, septic shock [infections] . The medical record lacked documentation of communication from the dialysis unit regarding Resident #183's condition during and after treatment. During an interview on 02/13/25 at 9:05 a.m., a staff nurse (#3) stated staff send an order sheet, medication list, and a copy of Resident #183's care plan with the resident to the dialysis facility. The nurse (#3) confirmed the dialysis facility does not send any further communication. During an interview on 02/13/25 at 11:50 a.m., two administrative staff members (#1 and #2) confirmed nursing staff do not receive hand off communication about the dialysis run from the dialysis unit regarding the resident's condition during and after treatments.

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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. 28398 Based on review of resident council minutes, staffing record review, confidential resident and family interviews, and staff interview, the facility failed to provide sufficient nursing staff and related services to meet the residents' needs for 4 of 4 residents (Resident B, C, D, and E) who require staff assistance. Failure to provide sufficient nursing staff may result in residents experiencing unmet needs, poor hygiene, incontinence, and skin issues and may negatively affect the residents' physical, mental, and psychosocial well-being. Findings include: Review of the resident council meeting minutes, dated November 2024-February 2025, identified the following resident concerns: waiting too long to use the bathroom, no clean towels provided over the weekend, on-going problem with weekend trash removal from rooms, waiting too long for call lights to be answered, staff turn off the call light without asking what the resident needed and leave the room, often only one CNA on the floor, and not enough staff. Resident and family interviews identified the following: * 02/10/25 at 1:01 p.m., Resident B stated, They fill up the place but don't have enough staff. In the last two weeks [the facility] brought in eight new people [residents] but no more staff. All three shifts don't have enough staff. Resident B stated he/she experienced incontinence while waiting for assistance, sometimes waiting a half-hour. * 02/10/25 at 2:40 p.m., Resident C stated when first admitted staff answered the call light in about five minutes, but now I can wait over an hour. * 02/10/25 at 3:35 p.m., Resident D stated, They are short on help, it often takes 20 minutes or more [answer call light] and by then you either [expletive] your pants or piss your pants. * 02/11/25 at 11:31 a.m., Family member E stated [resident name] said it takes up to a half-hour to answer call lights. The family member said they've visited at various times of the day and have witnessed call light wait times up to a half-hour and there is not enough help. During an interview on the morning of 02/13/25, a staff scheduler (#6) stated they increased the amount of CNA staff about 2-3 weeks ago when the census increased. Review of the staffing records from February 1-13, 2025 showed the facility failed to staff the total amount of increased CNA coverage on four of the past 13 days and a bath aide on two days. Refer to F600, F690, and F809.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 28398 Based on observation, record review, and staff interview, the facility failed to ensure posting of accurate staffing information on 4 of 4 days of survey (February 10-13, 2025). Failure to post accurate staffing data does not allow residents and visitors to be aware of the number of licensed and unlicensed staff on duty each shift. Findings include: Observation on all days of survey showed the Daily Staffing form posted in the hall by the residents' dining room. Review of the staffing forms showed the facility failed to post accurate information regarding the number of unlicensed staff working each shift from February 10-13, 2025. During an interview on the morning of 02/13/25, an administrative nurse (#1) and staffing scheduler (#6) agreed the daily staffing forms were incorrect.

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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. 45873 Based on observation, record review, review of facility policy, review of professional reference, and staff interview the facility failed to ensure a medication error rate of less than five percent for 3 of 5 residents (Resident #2, #4, and #5) observed during medication administration. Four medication errors occurred during staff administration of 26 medications, resulting in a fifteen 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 02/13/25. This policy, dated 09/05/24, stated, . Insulin Pen . Turn the dosage knob to '2' units to prime the pen. Holding the pen with the needle pointing upwards, press the button until at least a drop of insulin appears. Review of the facility policy titled Medications: Crushing occurred on 02/13/25. This policy, dated 01/31/24, stated, . Some medications, such as sustained release medications among others, are not to be crushed or chewed. Skidmore-Roth's Mosby's 2023 Nursing Drug Reference, 36th Edition eText, 2023, Elsevier - Evolve, page 704, stated, . Isosorbide Mononitrate - Do not break, crush, or chew . Information found at https://www.drugs.com/mtm/slow-mag.html, page 3, stated, How should I take Slow-Mag? . Swallow the tablet whole and do not crush, chew, or break it . - Review of Resident #2's medical record occurred on all days of survey. Physician's orders identified Slow-Mag (a delayed release combination calcium/magnesium supplement) and Isosorbide Mononitrate ER (extended release) (medication used to control chest pain). Observation on 02/12/25 at 8:28 a.m. showed a medication aide (MA) (#4) dispensed a Slow-Mag tablet and an Isosorbide Mononitrate ER tablet from Resident #2's medication card, placed the tablets into a cup along with other scheduled medications, poured the medications from the cup into a plastic sleeve, and crushed the medications. The MA then poured the crushed contents into pudding and administered the medications to Resident #2. The MA (#4) failed to follow manufacturer's instructions and crushed the Isosorbide Mononitrate ER and Slow-Mag. - Observations on 02/12/25 showed the following: * At 11:55 a.m., a nurse (#3) prepared a Humalog insulin pen for Resident #4. The nurse applied a needle, dialed the pen to two units, and with the needle pointed down, dispensed the insulin into a sink. * At 12:17 p.m., a nurse (#3) prepared an Insulin Lispro pen for Resident #5. The nurse applied a needle, dialed the pen to two units, and with the needle pointed down, dispensed the insulin into a sink. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse (#3) failed to prime the insulin pens with the needle pointed up. During an interview on 02/13/25 at 11:50 a.m., an administrative staff member (#1) stated she expected staff to prime insulin pens vertically and not crush delayed or extended-release medications.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 46477 Based on staff interview, the facility failed to ensure 1 of 1 dietary manager (#9) obtained the proper qualifications to serve as the director of food and nutrition services. Failure to ensure staff have the qualifications to carry out the functions of food and nutrition services has the potential to result in foodborne illness to residents, staff, and visitors. Findings include: During an interview on 02/10/25 at 1:52 p.m., the dietary manager (#9) stated he is currently enrolled in a certified dietary manager course but has not completed it. The facility failed to ensure the dietary manager (#9) completed the required education for a certified dietary manager, certified food service manager, or a national certification for food service management and safety from a national certifying body.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 46477 Based on observation, review of resident council minutes, and resident and staff interviews, the facility failed to provide snacks to residents within the facility. Failure to provide snacks may result in hunger, weight loss, and hypoglycemia (low blood sugar) for diabetic residents. Findings include: Upon request on the afternoon of 02/11/25, the facility failed to provide a policy on snacks. Review of the resident council meeting minutes, dated November 2024-February 2025, identified the following resident concerns: *11/27/24, Evening snack pass is happening more often but still not consistently. *12/18/24, Evening snack pass is inconsistent; residents still need to ask for evening snack. *01/14/25, The snack cart remains problematic. One resident often wanders and touches the food on the cart. [Resident #15] reported inconsistency in passing snacks to residents in their rooms. During an interview on 02/10/25 at 2:44 p.m., Resident #15 stated the snacks are delivered to the nurse's station and that's where they stay, they are not delivered to residents in their rooms. Resident #15 stated this happens way too often and I'm a diabetic and I sometimes need that snack. Observations on 02/11/25 showed the following: *3:04 p.m., Snacks delivered on a cart to the nursing station. *3:11 p.m., Resident #12 removed the plastic wrap from the plate of snack bars and touched then while several staff members stood or walked nearby. *3:15 p.m., An unidentified resident sat in the lounge and asked a certified nurse aide (CNA) (#11) for a snack. The CNA (#11) pulled the snack cart into the lounge and obtained a snack bar for the resident. Before the CNA could give the resident the snack bar, this surveyor informed the CNA another resident had touched the bars. During an interview on the afternoon of 02/11/25, a dietary manager (#9) stated, The kitchen provides the snacks, and we usually put them by the nurse's station. But we are not responsible for delivering them.

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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. 46477 Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure food is stored in accordance with professional standards for food service sanitation in 1 of 1 kitchen. Failure to ensure food is stored, prepared, and served in a sanitary environment may result in contamination for residents, visitors, and staff. Findings include: Review of the facility policy titled Food-Supply Storage -Food and Nutrition Services occurred on 02/12/25. This policy, revised on 05/07/24, stated, . Storeroom layout: 1. All food/supply items are stored six inches off the floor. 20. Employee . food/fluids are not stored in the preparation kitchen cooler/freezer or dry storage. Review of the facility policy titled Employee Hygiene and Dress Code occurred on 02/12/25. This policy, revised 06/12/24, stated, . Hairnets or hair restraints . are used: a. When cooking, preparing, assembling food or ingredients. This includes dish rooms and storage areas. Hair is to be covered completely . The 2022 Food and Drug Administration (FDA) Food Code, Chapter 3-16, stated, . 3-305.11 Food Storage. FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination . Annex 3 Page 100, stated, . 3-305.12 Food Storage, Prohibited Areas. Pathogens can contaminate and/or grow in food that is not stored properly. Drips of condensate . can be sources of microbial contamination for stored food. Observations of the kitchen showed the following: * On 02/10/25 at 1:32 p.m., The walk-in freezer contained condensation and ice-build-up on the ceiling and floor and boxes of food sat directly on the iced floor. The walk-in refrigerator contained a closed medication box and an unopened bottle of cola. The dietary manager (#9) stated, the medication and cola belong to a dietary staff member and, should not be in here we have an employee refrigerator. * On 02/13/25 at 10:03 a.m. Observation of the walk-in refrigerator at this time showed six large bundles of flowers. During an interview on 02/13/25 at 10:49 a.m., two administrative staff members (#1 and #2) confirmed kitchen coolers are to remain free from personal items, medications, and flowers.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 28398 Based on review of the State Agency (SA) facility files, survey findings, and staff interview, the facility failed to develop a Quality Assurance and Performance Improvement (QAPI) process to evaluate and identify problems and opportunities to improve services/outcomes, decrease or prevent likelihood of problems or occurrence of adverse events, and ensure compliance with federal requirements. Findings include: Review of the state agency files indicated the facility failed to maintain compliance at F657, F690, F725, F759, and F812 as indicated by deficiencies cited during the last standard survey on 02/01/24. Refer to F657, F690, F725, F759, and F812 for specific findings. During an interview on 02/13/25 at 12:01 p.m., an administrative staff member (#10) stated, We work as a team to develop the plan of correction and conduct audits following the federal survey. She stated the facility departments conducted various audits monthly, but was unaware if staff monitored the areas recited, other than care planning, Failure of the facility to effectively utilize QA resulted in continued noncompliance in the following areas: * F657 Care Plan Timing and Revision * F690 Bowel/Bladder Incontinence * F725 Sufficient Nursing Staff * F759 Free of Medication Errors * F812 Food Procurement, Store/Prepare/Serve-Sanitary

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 31725 Based on review of employee files, review of facility policy, and staff interview, the facility failed to employ an individual who has completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control program. Failure to employ an Infection Control Preventionist (ICP) may affect all residents, staff, and visitors, placing them at risk for acquiring infectious diseases. Findings include: Review of the facility policy titled Infection Preventionist and Control Program occurred on 02/13/25. This policy, dated 12/02/24, stated, . The SNF [Skilled Nursing Facility] Infection Preventionist must . Have completed specialized training in infection prevention and control . During an interview on 02/10/25 at 4:14 p.m., an administrative nurse (#1) confirmed the facility failed to have a staff member with specialized training in infection prevention and control.