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	03/18/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **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 ensure the residents' right to request, refuse, and/or discontinue treatment for 4 of 14 sampled residents (Resident #7, #10, #24, and #25) reviewed for advanced directives/code status. Failure to ensure the medical record and other forms of communication accurately reflected the code status discussed and agreed upon by the resident and/or the resident's legal representative limits the facility's ability to communicate to direct care staff and emergency personnel their wishes in the event of a medical emergency. Findings include: Review of the facility policy titled Advanced Care Planning occurred on [DATE]. This policy, dated [DATE], stated, . Advanced Directive: A written instruction . relating to the provision of healthcare when the individual is incapacitated. Informed Consent: The granting of permission by the resident and/or his or her legal representative . At the time of admission . staff . will inform the resident/healthcare decision-maker of the right to consent to or refuse medical treatment . all advance care planning discussions . must be documented in the medical record . Advanced directive orders are to be reviewed with resident/healthcare decision-maker at each care plan meeting . -Review of Resident #7's medical record occurred on all days of survey. A physician's order, dated [DATE], indicated cardiopulmonary resuscitation (CPR-full code status). The record lacked documentation the resident or representative agreed with the code status. -Review of Resident #10's medical record occurred on all days of survey. A physician's order, dated [DATE], indicated CPR. When asked for documentation showing the resident or their representative agreed with the code status, the facility provided a document signed by the resident and dated [DATE] (date during the survey). -Review of Resident #24's medical record occurred on all days of survey. A physician's order, dated [DATE], indicated CPR. The record lacked documentation the resident or their representative agreed with the code status. -Review of Resident #25's medical record occurred on all days of survey. A physician's order, dated [DATE], indicated CPR. The record lacked documentation the resident or their representative agreed with the code status. During an interview on [DATE] at 9:28 a.m., a management staff member (#8) confirmed staff failed to obtain signed documentation regarding the resident/resident representative's wishes regarding code status.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, review of the Resident Council meeting minutes, review of the facility bathing schedule, review of facility policy, and resident and staff interviews, the facility failed to ensure residents received the necessary services to maintain good grooming for 3 of 14 sampled residents (Residents #2, #3, and #36) and 1 supplemental resident (Resident #33) observed with unkempt hair and beards. Failure to ensure residents receive assistance with haircuts, grooming, and bathing may decrease the resident's self-esteem and quality of care. Findings include: Review of the facility policy titled Routine Practice occurred on 03/18/26. This policy, dated October 2025, stated, . Routine practices are services that are expected to be provided to all residents based on accepted, clinical guidelines and resident status and are not detailed on the care plan . Anticipate and meet needs . Baths/showers per week . Will be kept clean and free from odors . Review of the facility admission packet form titled Hair Care occurred on 03/18/25. This form identified the following options: * I would like hair care provided to me/my family member by a liscensed [sic] beautician. I understand that there is an additional charge. * I understand that the facility pays for one haircut every 4-6 weeks. Review of the Resident Council meeting minutes, dated 01/20/26, stated, . Residents asked if we will have a new beauty operator. - Observation on 03/15/26 at 4:00 p.m. showed Resident #3 with long hair. When asked how the resident prefers to wear his hair, Resident #3 stated, They don't have anyone [beautician] to give haircuts anymore. It's been a long time. -Observation on 03/16/26 at 10:10 a.m. showed Resident #2's hair over the tops of both ears. When asked how the resident prefers to wear his hair, Resident #2 stated, I could use a cut. It's been a while. -Observation on 03/16/26 at 10:53 a.m. showed Resident #33's hair over the tops of both ears and bangs covered a large portion of the left side of his face. When asked how the resident prefers to wear his hair, Resident #33 stated, I could use a cut. They used to have some lady do it but she hasn't been here for a while. During an interview on the afternoon of 03/18/26, an administrative staff member (#13) stated a beautician has not been in the facility since 12/22/25 and currently the facility does not have one. Review of the Resident Council meeting minutes, dated 02/03/26, stated, . several residents reported not receiving their weekly baths on schedule. -Review of Resident #36's medical record occurred on all days of survey. The current care plan identified extensive assistance of one staff member required for bathing and personal hygiene. Observation on 03/15/26 at 1:40 p.m. showed Resident #36 with long hair, a beard with thick hair growth on his neck, and food in the lower beard along the lip line. A certified nurse aide (CNA) (#12) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assisted the resident with toileting but failed to offer assistance to clean his face. Review of the facility bathing scheduled identified Resident #36 receives a bath on Wednesdays. Review of the bathing documentation, from 03/04/26 through 03/18/26, identified the resident received a whirlpool bath on 03/04/26 and on 03/18/26 (13 days without a bath). The medical record failed to identify Resident #36 refused a bath or if the facility rescheduled the bath that should have occurred on 03/11/26. During an interview on 03/16/26 at 4:14 p.m., an administrative staff member (#1) stated if a bath isn't completed on a resident's scheduled day, she expects the charge nurse to discuss with the resident if it is Ok to have their bath on a different day, and the nurse to document the conversation in the resident's progress notes. During an interview on the morning of 03/17/26, a CNA (#6) stated bath aides shave the residents on their bath day.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, review of facility policy, and staff interview, the facility failed to serve foods at a palatable temperature for 1 of 1 kitchen (tray cart to be served in parlor area). Failure to serve foods at a palatable temperature may result in decreased intake, weight loss, and inadequate nutrition.Findings include: Review of the facility policy titled Room-Tray Service-Food and Nutrition occurred on 03/17/26. This policy, revised March 2025, stated, . General . 6. Periodically monitor room/tray service to ensure quality and timeliness of service and compliance with food temperature standard. - Observation on 03/16/26 at 9:40 a.m. showed a cart containing food trays in the parlor area and Resident #10 was eating his meal. Facility staff served Resident #15 his meal tray of eggs and toast at 9:45 a.m. When asked if his breakfast food was warm, Resident #15 stated, No. Resident #10 said his food was also cold and stated, That's an everyday occurrence. Resident #28 received his tray at 9:50 a.m. and when asked about his meal, Resident #28 stated his eggs were cold. - Observation on 03/17/26 at 09:05 a.m. showed an unidentified dietary staff member placed covered room trays in the meal tray cart. A dietary staff member (#9) delivered the cart to the parlor area. A nursing staff member served the first room tray at 9:14 a.m. and the last tray at 9:44 a.m. A taste test conducted by the surveyors confirmed the food items were cold. - Observation on 03/18/26 at 9:15 a.m. showed a dietary staff placed food trays in the meal tray cart for delivery. At 9:50 a.m., a dietary staff member (#9) stated an administrative staff member (#10) asked her to check the temperatures on the tray cart because of the delay in delivery. The dietary staff member returned the meal tray cart to the kitchen and stated the kitchen staff will prepare warm food for the residents. During an interview on 03/18/26 at 4:05 p.m., an administrative staff member (#9) stated that the expectation is that certified nurse aides (CNA) serve the food trays immediately as there is an aide for each hallway and staff check food temperatures when there is a concern with late service/delivery.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and staff interview, the facility failed to inform 3 of 5 sampled residents (Resident #2, #7, and #17) or their representative on the risks and benefits related to the use of psychotropic medications. Failure to inform the resident or representative of the risks and benefits of psychotropic medication does not allow them to make an informed decision regarding his/her treatment options.Findings include: -Review of Resident #2's medical record occurred on all days of survey. A physician's order, dated 02/04/26, identified Zoloft (an antidepressant) daily. The record lacked evidence the facility informed Resident #2 or the resident representative of the risks and benefits associated with the use of the psychotropic medications. - Review of Resident #7's medical record occurred on all days of survey. A physician's order, dated 03/25/25, included Trazodone (an antidepressant) at bedtime. The record lacked evidence the facility informed Resident #7 or the resident representative of the risks and benefits associated with the use of the psychotropic medications.- Review of Resident #17's medical record occurred on all days of survey. A physician's order, dated 02/22/25, included Cymbalta (an antidepressant) daily. The record lacked evidence the facility informed Resident #17 or the resident representative of the risks and benefits associated with the use of the psychotropic medications. During an interview on the afternoon of 03/17/2026, an administrative nurse (#2) confirmed Resident #2, #7, and #17's records lacked documentation the residents or their representative received information related to the risks and benefits associated with the use of psychotropic medications.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and review of the Resident Council meeting minutes, the facility failed to provide privacy and ensure dignity during personal cares for 1 of 7 sampled residents (Resident #25) observed during personal cares. Failure to maintain a resident's privacy during cares is a violation of residents' rights and may decrease the resident's self-esteem and quality of life.Findings include:Review of the Resident Council meeting minutes occurred on all days of survey. The minutes, dated 12/10/25, stated, Staff should knock on the door, then wait for a response. They knock and come right in, even in the tub room. The minutes, dated 01/20/26, stated, Staff does consistently knock before entering rooms but sometimes don't wait long enough for a response.Observation on 03/15/26 at 2:04 p.m. showed a certified nurse aide (CNA) (#4) transferred Resident #25 from a wheelchair to the toilet to provide toileting cares. On two separate occasions, unidentified staff members knocked on the resident's room door, immediately opened the door, and began to enter the room. Both times, the staff noticed the surveyor in the room, stated, oh, closed the door, and left. Later, a CNA (#7) knocked on the resident's room door, immediately entered the room, and walked into the bathroom. When the CNA (#7) noticed Resident #25 on the toilet, the CNA backed out of the bathroom, knocked on the bathroom door, stated I just need to check something, reentered the bathroom, and reached for a container on a shelf above the toilet. The two unidentified staff members and the CNA (#7) failed to wait for acknowledgment from the CNA (#4) or Resident #25 before they entered the resident's room and bathroom.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on record review, review of facility policy, and staff interview, the facility failed to provide appropriate discharge planning to the resident or their representative for 1 of 2 closed records (Resident A reviewed for discharge. Failure to document the basis for Resident A's transfer and discharge in the medical record does not allow the resident and/or their representative to make informed decisions regarding their further care needs.Findings include:Review of the facility policy titled Discharge and Transfer occurred on 03/18/26. This policy, dated January 2026, stated, . Policy. The location permits each resident to remain in the location and does not transfer or discharge the resident from the location unless . The safety of individuals in the location is endangered due to the clinical or behavioral status of the resident. The basis for the transfer must be documented in the resident's record by a physician.Review of Resident A's medical record occurred on 03/18/26. Diagnoses included anxiety, depression, and a cerebral infarction (stroke). Medications included Melatonin (sleep aide), and Zoloft, an antidepressant initiated in April 2025 for a change in behaviors and anxiety.The current care plan included the following:*Initiated on 11/02/21, The resident wishes to remain in center [nursing facility] due to his needs for nursing care. Interventions included, Establish a pre-discharge plan with resident/family and evaluate progress and revisit plan (FREQ) [frequently].*Initiated on 10/05/24, The resident has displayed inappropriate sexual advances towards another resident and staff. Interventions included, Touching female resident: tell him to stop, immediately re-direct and report to nurse, and SEXUALLY INAPPROPRIATE: Monitor resident Q [every] 30 minutes. The care plan failed to identify an imminent discharge need due to behavioral changes.Resident A's progress notes included the following:*04/30/25 . Resident is alert and oriented. Mood is stable. [Family] visits often and helps make healthcare and financial decisions. Resident has previously had instances of inappropriate touching to female residents . Care plan reflects interventions. No recent occurrences. Discharge plan is to remain in center. *06/18/25 . Conversation with [Resident] about report of him attempting to grab between CNAs [certified nurse aide] leg/inner thigh. Reminded him this is not appropriate. Resident stated ?okay.' .*08/04/25 at 5:58 a.m. Resident grabbed CNA . during AM cares this morning. Was redirected and reminded it is inappropriate behavior. *08/04/25 at 3:24 p.m. Care Conference Note. All in attendance . [Family] . Off schedule care conference to discuss residents noted behavior. Will request a psych [Psychiatric] referral .*08/07/25 . Resident seen by [Physician] on rounds. Referral to Psych for consult.*08/26/25 Seen by . Rural Psych for inappropriate behaviors. New order for [increase in antidepressant medication dosage] .*08/28/25 at 11:39 a.m. Discharge Planning/Discharge. Resident sent to [medical facility] per [Physician] request. [Family] signed discharge form.*08/27/25 at 4:24 p.m. Late Entry Discharge Planning/Discharge Note Text: Resident referral sent to multiple facilities searching for placement.The medical record identified no inappropriate from 08/05/25 through 08/25/25.The medical record showed the facility transferred and discharged Resident A to an acute care hospital and subsequently discharged from the facility on the same day, 08/28/25. During an interview on 03/18/26 at 3:50 p.m. an administrative staff member (#8) confirmed the progress notes identified the facility sent referrals to various facilities for placement, however, could not provide the referral documents to show the number of facilities contacted, when they were contacted, and why they were unable to accommodate the resident's needs. The facility failed to assess Resident A's behaviors, monitor behaviors after a change in medication, revise the discharge plan, and consistently document the ongoing safety threat posed to other residents that would require an immediate discharge from the facility.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 notify the resident and/or representative of emergency room transfer for 1 of 5 sampled residents (Resident #9) reviewed for hospitalizations. Failure to inform the resident and/or their representative of a transfer does not allow for informed decisions regarding care. Findings include:Review of the facility policy titled Discharge and Transfer Rehab/Skilled, Therapy & Rehab occurred on 03/17/26. This policy, revised January 2026, stated, . 1. Notify the resident and the resident's representative of the transfer or discharge and the reason for the move in writing and in a language and manner they understand .Review of the facility form Hospital Transfer Checklist occurred on 03/17/26. The checklist states, . Notify family or guardian. Document in progress notes or in the . CICE [change in condition evaluation] .Review of Resident #9's medical record occurred on 03/17/26 and identified a transfer to the hospital on [DATE]. The facility failed to provide a written transfer notice to the resident and/or representative.During an interview on 03/16/26 at 4:10 p.m., an administrative staff member (#1) confirmed the facility failed to notify the resident's representative of the transfer.

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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 (Version 1.20.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 14 sampled residents (Resident #2 and #3). 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 A: IDENTIFICATION INFORMATION The Long-Term Care Facility RAI User's Manual, revised October 2025, pages A-30-32, stated, . Section A1500: Preadmission Screening and Resident Review (PASRR) . Coding Instructions . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . and continue to A1510 . Section A1510 . Coding instructions Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness . Review of Resident #2's medical record occurred on all days of survey and identified diagnoses of bipolar disorder and major depression since 2018. An annual MDS, dated [DATE], showed the facility failed to code Sections A1500 and A1510 for serious mental illness. During an interview the morning of 03/17/26, an administrative staff member (#2) confirmed the facility failed to correctly code Section A. SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2025, page N-8, stated, . Coding Instructions . N0415J1: Hypoglycemic (including insulin) . Check if a hypoglycemic medication was taken by the resident at any time during the 7-day observation period. N0415K1: Anticonvulsant: Check if an anticonvulsant medication was taken by the resident at any time during the 7-day observation period. Review of Resident #3's medical record occurred on all days of survey. Current medications included Metformin (a hypoglycemic medication) twice a day and Gabapentin (an anticonvulsant) four times a day. The quarterly MDS, dated [DATE], showed the facility failed to code the hypoglycemic and anticonvulsant medications. During an interview on 03/18/26 at 10:30 a.m., an administrative staff member (#2) confirmed the facility failed to correctly code Section N.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and review of facility policy, the facility failed to utilize assistive devices necessary to ensure safe transfers for 1 of 2 sampled residents (Resident #25) observed during gait belt and/or pivot transfers. Failure to utilize appropriate devices for safe transfers placed Resident #25 at risk of injury and/or falls.Findings include:Review of the facility policy titled Gait-Transfer Belt occurred on 03/18/26. This policy, dated 05/06/25, stated, . PURPOSE: To safely stabilize a transfer . To aid residents in maintaining balance. Do not use the pants/slacks belt as a gait (Transfer) belt.Review of Resident #25's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated [DATE], identified the resident does not walk due to safety concerns and required partial to moderate staff assistance with transfers. The care plan identified assistance of one staff member for transfers, toilet use, and personal hygiene related to weakness. Observations on 03/15/26 showed the following:*2:04 p.m., A certified nurse aide (CNA) (#4) placed a gait belt around Resident #25's waist and assisted the resident to pivot transfer from the wheelchair to the toilet, from the toilet to the wheelchair, and from the wheelchair to the bed while pulling on the gait belt and the back of the resident's pants. During each of the transfers, Resident #25's legs unsteady. *2:42 p.m., Resident #25 positioned diagonally in bed and activated the call light. A nurse (#3) answered the light, and when unable to locate a gait belt, placed an arm around the resident's back, assisted the resident to sit on the edge of the bed, placed a four-wheeled rolling walker in front of the resident, and asked her to stand. As the resident stood up, her legs were unsteady and the walker rolled away as she sat on the bed. The facility staff failed to utilize a gait belt to ensure safe transfers for Resident #25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and review of facility policy, the facility failed to provide appropriate respiratory care for 1 of 2 sampled residents (Resident #25) with orders for continuous oxygen. Failure to administer oxygen according to the physician's orders resulted in Resident #25 experiencing low oxygen saturation levels (level of oxygen circulating in the blood) and may compromise the resident's respiratory status. Findings include:Review of the facility policy titled Oxygen Administration, Safety, Mask Types occurred on 03/28/26. This policy, dated 07/30/25, stated, . Oxygen therapy is carried out only with a medical provider order. A licensed nurse or other employee trained . in the use of oxygen . will be . responsible for the proper administration of oxygen to the resident.Review of Resident #25's medical record occurred on all days of survey. A physician's order, dated 01/28/26, identified continuous oxygen via nasal cannula for oxygen saturation less than 88% (percent) for shortness of breath and low oxygen saturation levels. Observation on 03/15/26 at 2:04 p.m. showed Resident #25 seated in a wheelchair in her room. A certified nurse aide (CNA) (#4) removed the nasal cannula from the resident's nose, assisted the resident from the wheelchair to the toilet, and from the toilet back to the wheelchair. The resident appeared short of breath, and the surveyor asked the CNA (#4) to call the nurse to the room to assess the resident's respiratory status. At 2:30 p.m., a nurse (#3) entered the room, obtained an oxygen saturation reading of 82%, and the CNA (#4) applied the cannula into the resident's nostrils. At 2:37 p.m., Resident #25's oxygen saturation level varied between 92% and 94%. The facility staff failed to follow the physician's orders and left Resident #25 without oxygen for 26 minutes during transfers/toileting.

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and staff interview, the facility failed to post accurate and complete staffing information on 2 of 2 weekend days (March 14-15, 2026) reviewed. 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 03/15/26 at 12:15 p.m. showed staff postings for Thursday 03/12/26 and Friday 03/13/26. The facility failed to update the number of licensed and unlicensed staff working on the days of Saturday 03/14/26 and Sunday 03/15/26.During an interview on 03/15/26 at 12:30 p.m., a charge nurse (#3) confirmed the facility failed to update the staffing information for Saturday and Sunday.

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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. Based on observation, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 5 residents (Resident #18 and #19) observed during medication administration. Two medication errors occurred during staff administration of 25 medications, resulting in an eight percent error rate. Failure to administer medications at the correct time may inhibit the effectiveness of the medication, cause subtherapeutic levels, and may have a negative impact on the resident's overall health.Findings include:Prescribing information for levothyroxine (treats thyroid disorders), revised April 2019, found at https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/021116s017lbl.pdf, stated, . 2.1 General Administration Information Administer Levothyroxine Sodium Tablets as a single daily dose, on an empty stomach, one half to one hour before breakfast. Review of the facility policy titled Medication Administration Including Scheduling and Medication Aides occurred on 03/18/26. This policy, dated 04/08/25, stated, . Medication Administration . Follow the 'Six Rights': . Right Time . Observations on 03/17/26 during medication administration showed the following: *8:21 a.m., A nurse (#11) administered Resident #22's levothyroxine along with other scheduled morning medications, assisted the resident to the dining room, and the resident ate breakfast shortly after. *A nurse (#11) removed a 4% lidocaine pain patch from a box, entered Resident #18's room, and applied the patch to the resident's lower back. The provider's orders indicated to apply the patch to the resident's back at bedtime and remove the patch in the morning. (The patch from the previous evening was not present on the resident's back).During an interview on 03/17/26 at 11:42 a.m., the nurse (#11) confirmed he/she failed to administer the levothyroxine at least 30 minutes before breakfast on an empty stomach and failed to follow provider's orders when applying the lidocaine patch.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, review of professional reference, and staff interview, the facility failed to ensure safe and secure storage of medications and/or private health information on 1 of 1 medication cart and failed to ensure medication labels matched provider's orders for 2 of 5 residents (Resident #18 and #19) observed during medication pass. Failure to secure medications and electronic health information may result in unauthorized access and failure to ensure medication labels matched the provider's orders placed residents at risk for medication errors.Findings include:Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 838-840, stated, . Obtain the appropriate medication. Compare the label of the medication container or unit-dose package against the order on the MAR [medication administration record] or computer printout. Rationale: This is a safety check to ensure that the right medication is given. If these are not identical, recheck the prescriber's written order in the client's chart. If there is still a discrepancy, check with the pharmacist. Prepare the medication. While preparing the medication, recheck each prepared drug and container with the MAR again. Rationale: This second safety check reduces the chance of error. Lock the medication cart before entering the client's room. Rationale: This is a safety measure because medication carts are not to be left open when unattended.-Observations of the medication cart showed the following: *03/15/26 at 10:15 a.m., the cart located in the hallway outside the nurse's station unlocked and unattended for approximately 5 minutes in a high traffic area with staff and residents present. *03/16/26 at 8:07 a.m., the cart located in the 200 hallway unlocked, unattended, and the electronic medication administration record (eMAR) visible to staff and residents. Observation showed a resident attempting to get around the cart.-Observations on 03/17/26 during medication pass identified the following:*8:41 a.m., a nurse (#11) prepared Resident #18's medications. The eMAR identified pantoprazole 40 milligrams (mg) daily. The medication label indicated to administer the medication 30 minutes before breakfast. The eMAR failed to include to administer before breakfast. *4:13 p.m., a medication aide (MA) (#7) prepared Resident #19's medications. A provider's order in the eMAR identified pantoprazole 40 mg daily at 5:00 p.m. The medication label indicated to administer the medication at 9:00 a.m. and 9:00 p.m. (twice a day). The facility failed to ensure safe and secure storage of medications and private health information and failed to ensure the medication labels and provider's orders in the eMAR correspond. During an interview on 03/17/26 at 11:42 a.m., a staff nurse (#11) confirmed Resident #18 and #19's pantoprazole medication labels do not match the residents' eMARs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of facility policy, and staff interview, the facility failed to monitor temperatures and follow safe storage practices for 1 of 3 freezer units. Failure to keep freezer temperatures at 0 degrees Fahrenheit or below and monitor freezer temperatures may increase the likelihood of food borne- illnesses.Findings include: Review of the facility policy titled Food-Supply Storage-Food and Nutrition Services occurred on 03/18/26. This policy, revised March 2026, stated, Procedure. 13. In the freezer, the temperature is 0 degrees Fahrenheit or lower. The freezer . 14. internal temperatures of all freezers in the food and nutrition department, dining room, and nourishment areas are recorded twice daily . Review of the untitled facility document provided by administrative staff member (#9) on 03/18/26 showed lack of documentation for monitoring freezer temperatures of the freezer located in the parlor area from 12/01/25 through 03/09/26. - Observation of the parlor area freezer unit on 03/17/26 at 11:15 a.m. showed the freezer temperature at 6 degrees Fahrenheit. The staff member (#9) removed and disposed of the remaining food from the freezer. During an interview on 03/18/26 at 4:05 p.m., an administrative staff member (#9) stated he/she expected freezer temperatures at 0 degrees Fahrenheit or below.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of the facility's Quality Assurance Performance Improvement (QAPI) meeting sign in sheets, and staff interview, the facility failed to ensure all required members attended meetings at least quarterly for 2 of 4 quarters (November 2025 and February 2026) reviewed. Failure to have the medical director participate in the facility's quality assurance activities may result in an ineffective QAPI program and deprives the committee of the physician's unique contributions for analysis of quality concerns and assisting with decision making based on identified concerns.Findings include:Review of the QAPI meeting sign-in sheets, from March 2025 to February 2026 showed the medical director failed to attend any meetings since August 2025.During an interview on 03/18/26 at 3:30 p.m., an administrative staff member (#8) confirmed that the medical director failed to attend the required quarterly QAPI committee meetings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, review of facility policy, and staff interview, the facility failed to follow professional standards of infection control and prevention for 1 of 2 sampled residents (Resident #24) on enhanced barrier precautions (EBP) and 1 supplemental resident (Resident #22) during medication administration. Failure to practice infection control standards related to hand hygiene and glove and gown use has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Hand Hygiene occurred on 03/18/26. This policy, dated 11/13/25, stated, . HCW [healthcare worker] will use waterless alcohol-based sanitizer or soap and water to clean their hands: When entering the patient room. Before . administering medications. hand hygiene must be completed before donning gloves. After removing gloves . When exiting patient room. Review of the facility policy titled Standard, Enhanced Barrier, and Transmission-Based Precautions occurred on 03/18/26. This policy, dated July 2025, stated, . Enhanced barrier precautions expand the use of personal protective equipment . the use of gown and gloves during high contact care activities. Enhanced barrier precautions are used . for residents with chronic wounds . venous statis [sic] ulcers [chronic wounds due to poor blood circulation in veins] . High-contact resident care activities include transfers . providing hygiene, changing briefs or assisting with toileting. -Review of Resident #24's medical record occurred on all days of survey. The care plan identified EBP related to chronic venous stasis ulcers. Observation on 03/16/26 at 11:10 a.m. showed a certified nurse aide (CNA) (#4) entered Resident #24's room, performed hand hygiene, applied gloves, and assisted the resident with toileting. The CNA failed to wear a gown during high contact cares. -Observation on 03/17/26 at 8:21 a.m. showed a nurse (#11) prepared Resident #22's medications, carried them into the resident's room, and administered the oral medications. Without performing hand hygiene, the nurse applied gloves, administered eyes drops, removed the gloves, and without performing hand hygiene, exited the resident's room. During an interview on 03/17/26 at 11:42 a.m., the nurse (#11) confirmed he/she failed to appropriately perform hand hygiene during Resident #22's medication pass.