STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Lakota	608 4th Ave SW Lakota, ND 58344

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment/services to promote the healing or prevent the development of pressure ulcers for 2 of 3 sampled residents (Resident #1 and #2) identified with pressure ulcers. Failure to apply pressure relieving devices as ordered, complete weekly assessments with measurements of pressure ulcers per facility policy, may result in new pressure ulcers, the deterioration of existing pressure ulcers, and delayed healing. Findings include: Review of the facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation Requirements occurred on 01/08/25. This policy, dated April 2024 stated, . The pressure ulcer should be assessed/evaluated at least weekly . and should include at the least the following: Measurements - length, width, depth . Review of the Wound Data Collection form occurred on 01/08/25 and stated, . Measurements - Required at least every once every 7 days . - Review of Resident #1's medical record occurred on 01/08/25. Diagnoses included a history of urinary tract infections (UTIs), and clostridium difficile (inflammation of the colon caused by bacteria that can result in frequent diarrhea). The record identified a total of seven wounds, including two unstageable pressure ulcers and one stage two pressure ulcer. Physician's orders included weekly skin assessments, initiated 07/02/24; weekly registered nurse assessments, initiated 11/12/24; and wound care-right thigh, left gluteal fold, right gluteal fold - cleanse with wound cleanser, apply anasept gel (an antimicrobial skin and wound cleanser), with hydrogel gauze, cover dressings with border gauze every day shift and every one hour as needed for dislodged or soiled dressing, initiated 12/11/24. An initial assessment to Resident #1's left thigh wound, dated 11/07/24, measured 0.5 centimeters (cm) length x (by) 1.0 cm width x 0.1 cm depth. A second assessment, dated 11/19/24 (12 days later), failed to include measurements. Record review showed staff failed to complete weekly assessments and measurements after 11/19/24. An initial assessment to Resident #1's right thigh, dated 11/07/24, indicated an unstageable pressure ulcer and failed to include wound measurements. A second assessment dated , 11/13/24, showed a measurement of 2.5 cm x 4.0 cm. (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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A third assessment dated , 11/19/24, showed a measurement of 3.0 cm x 2.8 cm x 0.2 cm. A fourth assessment dated , 12/06/24, indicated a stage two pressure ulcer with a measurement of 1.8 cm x 1.8 cm. Record review showed staff failed to complete weekly measurements after 12/06/24. An initial assessment to Resident #1's right gluteal fold, dated 12/07/24, indicated an unstageable pressure ulcer and showed a measurement of 0.7 cm x 1.6 cm. A second assessment, dated 12/11/24, showed a measurement of 8.2 cm x 5.5 cm x 0.1 cm. Record review showed staff failed to complete weekly wound measurements after 12/11/24 even though the resident's wound increased in size. An initial assessment to Resident #1's left gluteal thigh, dated 11/19/24, indicated a stage two moisture related pressure ulcer and measured 0.8 cm x 0.5 cm x 0.1 cm. A second assessment, dated 12/06/24 (17 days later), stated . open wound with necrosis [irreversible death of body tissue) at the center. and measured 2.0 cm x 1.7 cm. A third assessment, dated 12/07/24, indicated an unstageable pressure ulcer with a measurement of 1.6 cm x 1.0 cm. Record review showed staff failed to complete weekly wound measurements after 12/07/24. An initial assessment to Resident #1's right buttocks, dated 12/06/24, indicated an unstageable pressure ulcer with a measurement of 3.0 cm x 2.5 cm. Record review showed staff failed to complete weekly wound measurements after 12/06/24. An initial assessment to Resident #1's coccyx wound, dated 11/19/24, failed to include measurements and stated, . multiple areas to coccyx/peri area have moisture related first layer of skin removed. Record review showed staff failed to complete weekly assessments with wound measurements after 11/19/24. An assessment to Resident #1's left buttock wound, dated 11/20/24, stated, . red area with scattered small open areas . and measured 11.1 cm x 9.0 cm x 0.1 cm. Record review showed staff failed to complete weekly assessments with wound measurements after 11/20/24. Review of nursing progress notes showed Resident #1 had multiple loose incontinent stools throughout the day and received loperamide (an anti-diarrheal) as needed for the loose stools. The electronic treatment record showed the facility staff completed dressing changes as ordered and as needed due to the loose incontinent stool. - Review of Resident #2's medical record occurred on 01/08/25. A significant change Minimum Data Set, dated dated dated [DATE], indicated two unstageable pressure ulcers. A physician's order, dated 12/19/24, stated, . Bilateral heel check for wound condition, offloading and heel protector boot placement BID [twice a day]. Bilateral heels must remain raised offloaded in bed and chair. Keep heel protector boots on at all times. Observation on 01/08/25 at 10:04 a.m. showed Resident #2 in the recliner in his room, with a pillow under his knees and his heels resting directly on the foot rest of the recliner, without protector boots in place. Observation on 01/08/25 at 12:00 p.m. showed Resident #2 in the recliner in his room, with bilateral heels resting over the edge of the recliner's foot rest, without protector boots in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to follow pressure relief interventions as identified by the physician's orders. Assessments of Resident #2's right heel pressure ulcer showed the following: * 11/24/24 - 2.2 cm x 3.1 cm. * 12/07/24 - 3.0 cm x 3.5 cm., (13 days later) * 12/19/24 - 1.1 cm x 1.6 cm., (12 days later) * 12/25/24 - 1.0 x 0.6 cm. * 12/30/24 - 1.0 cm x 1.0 cm * Record review showed staff failed to complete weekly wound measurements. Assessments of Resident #2's left heel pressure ulcer showed the following: * 12/07/24 - 2.0 cm x 2.5 cm. * 12/19/24 4 cm x 5 cm., (12 days later) * Record review showed staff failed to complete weekly wound measurements after 12/19/24 and showed the resident's pressure ulcer increased in size. During an interview on 01/08/25 at 1:30 p.m., and administrative staff member (#1) verified the facility failed to ensure interventions were being followed and the medical record lacked weekly wound measurements. The facility failed to complete weekly assessments with measurements to monitor Resident #1 and #2's pressure ulcers to determine further treatments and interventions to prevent the deterioration of the pressure ulcers.

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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 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** 40489 Based on record review and staff interview, the facility failed to ensure appropriate care and services for 1 of 1 sampled resident (Resident #1) with an indwelling urinary catheter. Failure to obtain a physician order for an indwelling urinary catheter, and provide catheter care may result in urinary tract infections (UTI's), unnecessary discomfort, unnecessary skin issues, and/or sepsis. Findings include: Review of Resident #1's medical record occurred on 01/08/25. Diagnoses included retention of urine, pressure ulcers, resistance to multiple antimicrobial drugs and recurrent UTI's. The quarterly Minimum Data Set, dated dated [DATE], identified a urinary catheter. The care plan stated, . indwelling medical device (foley catheter) . Review of the medical record included a nurse practioner's note dated 12/18/24 and stated, . Patient returned to nursing home [from hospital] on 11/18/2024. A trial off the foley catheter occurred shortly after return with noted urinary retention. She has a urology consult 2/12/2024 (sic) for urinary retention and recurrent UTIs. Review of Resident #1's progress notes included the following: * 11/19/24 at 3:07 p.m. catheter draining yellow urine. * 12/25/24 at 4:14 p.m.Indwelling foley catheter replaced today with 16fr [french] Cathether (sic). The facility failed to obtain a physician order for an indwelling foley catheter and how often to change the catheter. During an interview on 01/08/24 at 1:20 p.m., an administrative staff member (#1) confirmed Resident #1's medical record lacked an order for the catheter.